

Communities of Excellence in Tobacco Control:  
**Findings from 2001**



**California**  
**Department of**  
**Health Services**  
**Tobacco Control**  
**Section**

**October 2003**

**Gray Davis**, Governor  
State of California

**Grantland Johnson**, Secretary  
Health and Human Services Agency

**Diana M. Bontá, R.N., Dr.P.H.**, Director  
Department of Health Services



October 2003

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Suggested citation:

Roeseler A., Cowling D.W., Tang H., Sisneros H., and Pacheco A. *Communities of Excellence in Tobacco Control: Findings of the California Department of Health Services, Tobacco Control Section: October 2003*. Sacramento, California. 2003.

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## Executive Summary

### Overview

Communities of Excellence in Tobacco Control (CX) is a planning framework introduced to local health departments in California in October 2000. Development of the framework was led by the California Department of Health Services, Tobacco Control Section (CDHS/TCS) who relied upon the expert advice of a workgroup composed of local health departments, ethnic networks, regional community linkage projects, voluntary health groups, and universities. Other local, state, and national tobacco control experts were involved in rating the tobacco control indicators and assets that form the foundation for the community needs assessment component of CX. Additionally, the CX needs assessment tools were pilot tested within rural, suburban, and urban settings prior to their statewide rollout.

CDHS/TCS required the use of CX as part of the development of the three-year comprehensive tobacco control plan that local health departments submitted to CDHS/TCS for the period July 1, 2001 through June 30, 2004. Development and submission of these plans came on the heels of more than a decade of tobacco control work by local health departments in California, and following two events that had the potential to infuse additional financial and human resources into California's tobacco control movement. These two events were: 1) the Master Settlement Agreement (MSA) between the State Attorneys General (AG) and the United States (U.S.) tobacco companies, and 2) passage of the California Children and Families (CCF) Act (Proposition [Prop] 10), which raised the tobacco tax in California by 50 cents and authorized use of a portion of the funds on tobacco control activities targeting families with young children.

CDHS/TCS had four goals in mind with the introduction of CX:

1. Broaden the membership and participation of the community in local tobacco control planning;
2. Implement a systematic framework for assessing community needs and assets;
3. Develop meaningful local tobacco control plans that emphasize community norm change strategies based on assessment findings; and,
4. Strengthen the State's evaluation of local program efforts by standardizing local program evaluation, examining similar interventions, and analyzing the factors that contribute to successes.

To facilitate implementation of CX, CDHS/TCS provided two, one-day trainings that were required for local health department staff. Coalition members, competitive grant projects funded by CDHS/TCS, and the American Cancer Society (ACS) local staff also attended. Additional resources provided to local health departments included: a detailed planning guide, a local program evaluation guide, a two-day training on the guidelines to prepare the 2001-04 comprehensive tobacco control plan, a technical assistance (TA) meeting prior to submission of the plan which included facilitated small group discussions and individual evaluation consultation from university-experienced evaluators. Each local health department subsequently submitted their CX needs assessment findings and the tobacco control plan to CDHS/TCS via the Online Tobacco Information System (OTIS).

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Following final approval of local health department tobacco control plans, CDHS/TCS conducted an evaluation of CX. The evaluation was based on input from local health department program staff, Local Program Evaluators (LPEs), and CDHS/TCS staff. Data was collected using electronic and paper and pencil survey instruments.

## Major Findings

- The training and TA resources provided by CDHS/TCS aided implementation of CX and facilitated the development of well written comprehensive tobacco control plans by local health departments.
- Those who used the provided resources benefited the most from their participation in CX.
- Local health departments were very successful at involving their coalitions in meaningful tobacco control planning activities that went beyond merely acting in an advisory capacity, and the majority of local health departments reported that their coalitions were satisfied with their participation in CX.
- The majority of local health departments were not successful at involving nontraditional community members in CX.
- The majority of local health departments reported that the search for data was somewhat or very difficult; however, the majority reported that the compilation of the data educated coalition members and was somewhat or extremely helpful.
- CX was a helpful planning approach in that two-thirds of those surveyed indicated that participating in the CX needs assessment process yielded results not anticipated prior to undertaking the assessment process.
- The final comprehensive tobacco control plans that resulted from CX were well-grounded in the CX needs assessment findings and the majority of plans were well written, had measurable objectives, activities that matched the objectives, and appropriate evaluation designs.
- There were no significant differences between rural and suburban/urban communities in how CX was perceived or implemented by local health department staff. CDHS/TCS staff perceived that suburban/urban health departments were more likely to broaden their coalitions as a result of participating in CX than those in rural areas and also more likely to use the *Local Program Evaluation Planning Guide*.
- The two greatest barriers to implementing CX were the time commitment involved and the lack of sufficient local data for the assessments.
- The greatest benefits to implementing CX identified were that the CX assessment provided a planning framework that assisted local health departments to grasp the big picture with regards to tobacco issues in their community, and it resulted in an increase in coalition and community involvement in tobacco control planning.
- A large portion of the LPEs and project directors agreed that LPEs need more training and tutoring related to evaluation. However, the peer-to-peer consultation approach (using university-based/experienced expert technical assistance consultants [TAC]) received mixed reviews as a means to do this.

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These evaluation results support the conclusion that CX has merit as a means to facilitate a systematic approach to conduct program planning. Use of CX resulted in increased community involvement in program planning and led to the development of quality tobacco control plans based on needs assessment findings. CX also contributed to the development of high quality local program evaluation plans.

One of the challenges faced by comprehensive tobacco control programs is the ability to collect information on diverse and numerous local program interventions, their outcomes, and then to assess and understand the statewide impact of local program efforts.<sup>1</sup> CX, in conjunction with an online tobacco information system, is a valuable tool to address this challenge. Use of an indicator-based needs assessment and development of a tobacco control plan based on indicators provides standardization and a common language across local program interventions and evaluation designs. Together, CX and online information systems can generate data that will help to: 1) better understand the link between intermediate indicators and final tobacco-related outcomes; 2) uniformly collect information on the social, cultural, and political environments that may foster or hinder tobacco control efforts locally; 3) provide a means to compare communities; and, 4) assess the impact of individual or program components.

While it is evident that use of CX provided significant and tangible gains, it is also evident that implementing CX involved a substantial commitment to the process in terms of time and resources. The investment of training, TA, and other resources on the part of CDHS/TCS was not inconsequential. However, it is evident that these resources contributed to the success of the implementation of CX. It is also evident that local health department staff and their coalition members expended considerable resources, especially in staff time to conduct the CX needs assessment and develop the Comprehensive Tobacco Control Plan. To maximize the benefit of CX to local communities, the burden of the time commitment needs to be decreased. Some of this may be possible through improved access to local data sources, better use of technology (e.g., conference calls and web boards) to collaborate with coalition and community members, and decreased complexity of resource materials and instructions.

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## Chapter 1

### Purpose of CX and this Evaluation

#### Introduction

CX is a community planning framework to systematically assess communities in relation to a set of standardized indicators and assets that address tobacco control issues. At the heart of CX is the idea that communities can achieve excellence in tobacco control by involving a motivated and diverse group of people in planning a local tobacco control program that fits the needs of their community.

#### CX Goals

CDHS/TCS had several goals for the introduction of this planning framework. It was rolled out with 61 local health departments that were creating new three-year comprehensive tobacco control plans. These goals were to:

1. Broaden the membership and participation of the community in local tobacco control planning;
2. Implement a systematic framework for assessing community needs and assets;
3. Develop meaningful local tobacco control plans that emphasize community norm change strategies based on assessment findings; and,
4. Strengthen the State's evaluation of local program efforts by standardizing local program evaluation, examining similar interventions, and analyzing the factors that contribute to successes.

#### Features of CX

California's version of CX was designed to incorporate four principles that guided several past successful tobacco control efforts in California. These were:

1. **Involve the Grassroots Level:** CX was designed to engage local coalitions in a process of reflection in terms of where they had been and where they needed to go after a decade of tobacco control work. Involvement of the community in the assessment and planning process (versus a staff-only approach) was viewed as essential in order to plan for and achieve lasting community norm changes that would be "owned" by the community.
2. **Focus Locally:** California has learned that the most significant and cutting edge progress in tobacco control results from action initially initiated at the local level as opposed to action initiated at the state level action without prior broad local support. Therefore, engaging the local level in policy and other community-norm change strategies is emphasized throughout CX.
3. **Collect Data Systematically and Use Local Data Strategically:** CX emphasizes the use of local data as much as possible to drive decision-making because local data

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resonates more meaningfully with local decision-makers. However, the framework also acknowledges that local data is not available for every indicator. CX provides the flexibility to augment local data with regional and statewide data, and to incorporate qualitative data.

4. **Link Local Autonomy with Standardization:** While California's geography, industry, demographics, and political viewpoints are highly varied and diverse, its communities also have much in common. CX accommodates this diversity and the need to define excellence locally. At the same time, it creates a uniform language to better understand the tobacco control related commonalities and differences between communities. The indicators and assets provide a means for each community to take a snap shot picture of tobacco control using the same reference point. It allows communities to describe differences based on uniform characteristics such as the amount of public support and the presence or absence of: educational and media activities, locally initiated voluntary or legislated policies, enforcement, and compliance.

## **Purpose of the Evaluation**

The purpose of this evaluation was to determine the extent to which the first three goals for the planning framework were met. The evaluation also assessed: 1) the value of the CX training and TA resources provided; 2) barriers and benefits of implementing CX; and, 3) the perceived impact of CX's use related to the quality of the needs assessment, local program plan, and evaluation plans submitted to CDHS/TCS by the local health departments. Determining the extent to which the fourth goal of CX was met (i.e., strengthening the State's evaluation of local programs) will be determined after June 2004 when final evaluation reports are submitted to CDHS/TCS by local health departments. Data for this evaluation was collected from different entities: local health department staff, CDHS/TCS state program consultants, and LPEs.

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## **Chapter 2**

### **Program Description**

#### **Background**

California voters approved the Tobacco Tax and Health Protection Act in November 1988 (Prop 99), which raised the tobacco tax in California by 25 cents and earmarked 20 percent of the funds collected for a comprehensive tobacco control program jointly administered by CDHS and the California Department of Education. The enabling legislation that established California's comprehensive tobacco control program designated the 61 local health departments that serve 58 counties and three cities as local lead agencies (LLAs).

Local health departments are legislatively mandated to periodically submit a comprehensive tobacco control plan to CDHS, and to obtain the involvement of local community organizations in the development of that plan. The legislation requires that the plan provide demographic information; local data on smoking and tobacco use; a description of program goals, objectives, target populations, activities, and evaluation; budget cost estimates for program activities; budget information including staffing configurations; and computer hardware and software needs and plans. Additionally, the enabling legislation requires local health departments to use a uniform management data and information system, which will permit comparisons of workload, unit costs, and outcome measurements on a statewide basis.<sup>2</sup>

#### **The Changing Tobacco Control Landscape**

After a decade of funding local tobacco control programs, CDHS/TCS believed it was very important for local health departments to take a critical and methodical look at their communities to determine what had been accomplished in the past decade and what remained to be done. Additionally, two major events occurred in 1998 that had the potential to dramatically alter the landscape of tobacco control locally. These were the MSA and the CCF Act (Prop 10) both of which are discussed below. These events served to reinforce the need for a systematic assessment of tobacco control throughout California.

The MSA between major U.S. tobacco companies and 46 AGs was projected to result in payments to California of \$25 billion through 2025. As a result of a Memorandum of Understanding (MOU) signed between the California AG and local governments there was a 50/40/10 split of the tobacco industry payments between the State (\$12.5 billion), the counties (\$10 billion), and four cities (Los Angeles, San Diego, San Francisco, and San Jose) receiving \$2.5 billion. Since there were no restrictions on the use of the MSA funds, local governments could potentially allocate significant funding for tobacco control activities above and beyond that available to the local health departments through Prop 99.

Prop 10 was another factor that had the potential to significantly alter the local tobacco control landscape. Prop 10, enacted by voters in November 1998, increased the excise tax on cigarettes by 50 cents per pack beginning in January 1999, and established the CCF Act. It was estimated that the new tax would generate about \$700 million annually. While Prop 10 was primarily enacted to promote early childhood development, efforts to

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encourage pregnant women and parents of young children to quit smoking were among the activities to be addressed by the CCF Act.

The CCF Act established 58 county commissions that receive 80 percent of Prop 10 funding. The other 20 percent of the funds go to a state commission responsible for conducting a statewide media campaign; development of educational materials; parent and professional training; childcare programs and training for childcare providers; early childhood development research and evaluation; administration; and general purposes. The CCF Act provided an opportunity for additional funding directed at tobacco cessation for pregnant women and parents of young children as well as an opportunity for local health departments to partner with new groups that may not have previously been involved in tobacco control activities.

## **Development of CX**

It is within this context that CDHS/TCS set about developing a framework for local health departments to conduct a community needs assessment and develop a three-year comprehensive tobacco control plan for the period July 1, 2001 to June 30, 2004. Development of CX was the result of a partnership among local, regional, state, and national groups. In the summer of 1999, CDHS/TCS convened a workgroup of several local and regional projects that had performed exemplary work in community assessment and planning activities, and had involved coalitions and community groups in those activities.

Originally known as the “Tobacco-Free Communities” Workgroup, this Workgroup sought to develop a community planning tool for integration into the 2001-04 Comprehensive Tobacco Control Plan (Plan) to be developed by each of the local health departments. Since every local health department would be required to participate in the community assessment process, the Workgroup recognized that the tools had to be flexible enough to address a diverse group of counties that range from Alpine County with a population of 1,200, to Los Angeles County with a population of ten million.

The Workgroup considered setting a series of benchmarks which each local health department would use to rate itself against, but concluded that this approach was inappropriate and would be unworkable. The Workgroup then began to focus on creating a series of community-level indicators. For a model, the Workgroup turned to work completed by the Centers for Disease Control and Prevention (CDC) in the development of promising community-level indicators for cardiovascular health promotion programs and work done by Ross Brownson, Ph.D., School of Public Health, St. Louis University, regarding community indicators for physical activity.<sup>3, 4, 5</sup>

At the same time California was conceptualizing its “Tobacco-Free Communities” approach, CDHS/TCS learned that the ACS-National Home Office (ACS-NHO) was embarking on the development of a similar planning model. ACS-NHO was developing a document to help prepare local communities across the country to effectively plan the use of MSA funds that would likely become available for local tobacco control activities in many states.<sup>6</sup>

There were many similarities between the efforts underway in California and those of ACS-NHO. Rather than create separate identities for efforts aimed at enhancing local

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tobacco control planning, it made sense to create a national identity. California merged its efforts with ACS-NHO with the understanding that the two products did not need to be identical.

A focal point for CX in California was implementation of a uniform needs assessment process that would involve community members. The needs assessment was a requirement for funding in California and centered on assessing the community against a set of standardized community indicators and assets.

Community indicators were defined as tobacco control related environmental or community level measures that provide a means to assess change at the community level versus the individual level. Indicators represent intermediate goals of a community-focused tobacco control program. (See Appendix 1 for a list of indicators.) An example of a community indicator is as follows:

“Extent of tobacco sponsorship at public (e.g., county fair) and private events (e.g., concert, bars) –or–the proportion of entertainment venues with policies that regulate tobacco sponsorship.”

Community assets were defined as factors that promote excellence in tobacco control by indirectly facilitating tobacco control work. Assets include such things as the level of funding available for tobacco control work; the extent of community activism among youth and adults; the level of support by local opinion leaders for community norm change strategies; and awareness of and sensitivity to cultural diversity within the tobacco control program (see Appendix 2 for a list of assets). An example of a community asset is as follows:

“Extent MSA funds are appropriated for the purpose of tobacco control activities.”

The Workgroup developed the community indicators and assets. They were then rated for their quality (ability to move tobacco control forward) and their feasibility (ease of data collection/availability of data) by more than 70 tobacco control experts who work locally at the state, national, and international levels. Indicators that were scored as high or very high by 80 percent or more of raters on quality and that were also scored as high or very high on feasibility by 50 percent or more of raters, were selected for consideration as a “core indicator.” The indicators that met the established cut points were considered by the Workgroup and pilot projects. Based on that discussion, 13 of the 62 final indicators were identified to be the “core” indicators. Additionally, all 14 of the community assets were identified as “core” assets. CDHS/TCS required each local health department to complete assessments for the 13 core indicators and 14 assets. Additionally, they were required to select and assess three noncore indicators because the Workgroup felt the core indicators represented traditional areas of tobacco control work and wanted to encourage exploration into new areas.



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The Workgroup also developed the community assessment forms for the indicators and assets. The indicator assessment form required that each indicator be rated in terms of nine attributes. These were as follows:

- Public Awareness
- Public Support
- Media Attention
- Education/awareness
- Media Campaign
- Voluntary Policy
- Legislated Policy
- Active Enforcement
- Compliance

Each of the attributes was rated on a scale of “None” to “Excellent.” Responses for “Insufficient Data” or “Not Applicable” were permitted (e.g., enforcement is not relevant to the cessation indicators and would be marked as “not applicable”).

A comment field was provided for the agency to provide data/information to justify the rating given to individual attributes, (e.g., the rate of illegal tobacco sales, information on educational or media activities conducted, the quality of a local legislated policy, whether enforcement agencies responded to complaints only or conduct proactive enforcement operations). For each indicator an overall rating was also given.

While the ratings do not reflect a precise measure, they represent the consensus viewpoint of the coalition members. To decrease the variability in ratings across local health departments, CDHS/TCS provided a rubric that served as a guide to determine whether to assign a rating of “None” to “Excellent.” Assets were rated similarly and a rating rubric was provided for the assets as well.

The assessment forms and instructions were pilot tested in four areas of the state: in a small rural county; a medium sized suburban county; a large urban county; and a three-county region that included a mix of rural, suburban, and urban communities. Based on the pilot testing, the forms and instructions were revised. A number of other items were developed following the pilot testing. These were the rating guide (rubric) to facilitate consistent rating; tips to identify data sources and involve new partners; role delineation suggestions; priority setting tools; and sample objectives for each of the core indicators and assets.

These items were packaged together in the *Communities of Excellence in Tobacco Control Community Planning Guide (CX Planning Guide)*. The *CX Planning Guide* was originally issued in draft form at the CX trainings in October 2000. Modifications were made to the *CX Planning Guide* based on comments from trainees, and the final version was disseminated in November 2000.

A complementary evaluation-focused companion to the *CX Planning Guide* was developed and disseminated in May 2001. The *Local Program Evaluation Guide* provided multiple sample evaluation designs for 24 sample objectives addressing the 13 core indicators.

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In October 2000, two CX trainings (one each in Southern and Northern California) were conducted for local health departments. The trainings were mandatory for health department staff, who were also encouraged to bring local coalition members, their LPE, and local ACS staff. Other CDHS/TCS contractors were also invited to participate, but not required to do so. The trainings were delivered by CDHS/TCS staff, Workgroup members, staff from the pilot projects, and staff from ACS-NHO.

## **Local Health Department Tobacco Control Plan Requirements**

In January 2001, CDHS/TCS provided local health departments detailed written guidelines for preparing and submitting their plan. A two-day training was conducted that reviewed requirements for the plan, as well as various policy, coalition building, and evaluation strategies. CDHS/TCS also provided local health departments with preliminary information regarding an online database system that was under development and which would be used as the vehicle to submit their plan.

CDHS/TCS required local health departments to submit a plan that provided the following:

- Coalition operations and membership description;
- Media outlets list;
- CX needs assessment findings;
- Scope of work that included outcome objectives and a detailed activity and evaluation plan for each objective;
- Educational and media materials to be developed;
- Narrative that summarized the plan and provided a theory of change for each objective; and
- A budget.

In May 2001, CDHS/TCS conducted a follow-up TA meeting for local health department staff and LPEs. The TA meeting included a series of round table discussions on various intervention and evaluation activities and provided the opportunity for local health department staff and their LPEs to receive individualized consultation on their draft plans from CDHS/TCS program and budget staffs, as well as evaluation consultants hired by CDHS/TCS, and known as Technical Assistant Consultants (TACs).

CDHS/TCS recognized that the expertise of LPEs varied greatly and that measurable objectives and solid evaluation designs were crucial for obtaining valid findings two or three years downstream. Consequently, the TACs were to provide peer-to-peer TA to LPEs in order to improve local evaluation efforts. Obtaining valid local evaluation findings was seen as key to future state-level evaluation efforts planned by CDHS/TCS. These plans included conducting meta-analyses and the development of a local strength-of-tobacco-control construct.

In May 2001, CDHS/TCS realized that OTIS, which the local health departments were to use to submit their plans, would not be completed in time for the submission and review of plans prior to the July 1, 2001, start date. A somewhat satisfactory solution to this problem was that local health departments submitted an “abbreviated plan” in hard-copy format in

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mid-June. The abbreviated plan consisted of a cover sheet, the CX needs assessment worksheets for the indicators and assets, a letter from the project's LPE discussing their involvement in the development of the plan, and the scope of work narrative summary. Based on the submission of these documents, contract agreements were finalized and payments to local health departments sustained.

In mid-July 2001, CDHS/TCS staff and TACs reviewed the abbreviated plans and provided detailed comments to improve and modify the plans. Based on these comments the local health departments revised their plans prior to entering them into OTIS. In late July 2001, CDHS/TCS conducted eight trainings on the use of OTIS. Local health departments were given until September 7, 2001, to submit their plans through OTIS.

After the plans were submitted, they were reviewed by CDHS/TCS program, evaluation, and budget staff, as well as TACs. Comments were provided to each health department electronically. Additionally, teleconferences or in-person meetings occurred with the majority of health departments. The plans were approved in sections. Local health department staff were instructed that they did not have approval to work on a particular objective until it and the corresponding program and evaluation activities, were approved. OTIS permitted CDHS/TCS staff and TACs to identify whether requested revisions were made by "logging" the previous version and the current version of the information submitted. As sections of the plan were approved, they were "frozen" so that further edits could not be made to the information without first contacting CDHS/TCS.

#### CX and 2001-04 Plan Timeline

July 1999	Tobacco Free Communities Workgroup formed
November 1999	CX concept introduced at the Project Directors' meeting
July 2000	Partner with ACS-NHO
October 2000	CX Trainings conducted
January 2001	2001-04 Plan guidelines released and training conducted
February 2001	OTIS development begins
May 2001	TA meeting conducted Evaluation resource guide disseminated
June 2001	Abbreviated 2001-04 Plans submitted
July 2001	Abbreviated plans reviewed and comments provided OTIS trainings conducted
September 2001	Final 2001-04 Plans submitted through OTIS

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## **Chapter 3 Methods**

### **Local Health Department Staff User Survey Methods**

The survey instrument to assess the experience local health department staff had with CX was passively distributed electronically through the online tobacco control system known as Policy Advocacy Resource Tobacco Network Education Response System (PARTNERS). This is a password protected Web-based system available only to CDHS/TCS contractors and collaborators. Users had to actively log on to the system to access the survey. Since contractors are required to log on at least one time per week, the system is an excellent vehicle for disseminating surveys.

The survey was promoted prominently through the *TCS Update*—an electronic newsletter available through PARTNERS that is published weekly and was promoted through word-of-mouth. The survey was available for completion from September 17, 2001, through October 1, 2001. Of the 61 local health departments that participated in CX, 57 staff representing 54 local health departments (88.5 percent) participated in the survey. Survey respondents had the choice of identifying themselves or anonymously responding to the survey.

The survey consisted of 15 questions on a four-point Likert Scale and solicited additional comments. There were also four open-ended questions. Online survey responses were automatically placed into a tab delimited text file. Respondents provided voluminous comments in response to the scaled and open-ended questions. Content analysis of the comments and identification of themes was conducted by a four-member team. The coded comments were entered into an Excel spreadsheet. Descriptive statistics of the quantitative and qualitative information were calculated using SAS.

### **State Program Consultant Staff Survey Methods**

CDHS/TCS staff completed a paper and pencil survey instrument in September 2001. The purpose of this survey was to solicit perceptions of CDHS/TCS staff about the: 1) utilization of the CX TA resources by local health departments in developing their plan; 2) extent to which each local health department benefited from their participation in CX; and 3) quality of the relationship and services provided by TACs.

One survey was distributed to each CDHS/TCS staff person for each local health department plan they were responsible for reviewing and approving. The staff person and the local health department assigned to that staff person were identified on the survey instrument. Twelve program consultants, supervisors, or managers who were assigned responsibility for negotiating the 60 plans completed the surveys (one local health department failed to submit a plan until January 2003 and was not included in this review). Staff had responsibility for one to eight plans each. There was a 100 percent completion rate by staff.

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The survey instrument consisted of 16 questions on a five-point Likert Scale. Responses were entered into an Excel spreadsheet and descriptive statistics were calculated using SAS.

## **Local Program Evaluator (LPE) and Local Project Director TA Survey Methods**

A third survey of LPEs and local project directors was conducted to determine their experience with the expert evaluation assistance provided by TACs. The survey of LPEs was distributed in an online PARTNERS survey in November 2002. The survey consisted of 15 questions on a five-point Likert Scale, three multiple choice questions, and one open ended question. There was a 34.4 percent (21) response rate to the survey by LPEs. The survey of local project directors was also distributed through PARTNERS. Their survey consisted of 17 questions on a five-point Likert Scale and one open-ended question. There was a 54 percent (33) response rate from local project directors. The initial posting on PARTNERS was followed up with an e-mail reminder to complete the survey. Online survey responses were automatically placed into a tab delimited text file. Descriptive statistics were calculated using SAS.

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## Chapter 4

### Local Program Staff User Results

#### Introduction

Findings are presented here from the local health department staff user survey in which 57 staff responded. The quantitative findings are discussed first. This is followed by a discussion of the qualitative findings which help to illustrate and provide insight into helpful or problematic features of CX. Tables for the quantitative findings are presented at the end of each discussion. Percentages in tables were rounded and may not total 100 percent due to rounding error.

#### CX Training and Resource Guides

Local program staff assessed the value of the one-day CX training and two resource materials provided to them to: 1) implement the CX needs assessment; 2) develop their comprehensive tobacco control plan; and 3) develop appropriate evaluation activities related to objectives and interventions. The resource materials were the *CX Planning Guide* and the *Local Program Evaluation Guide*.

##### CX Training

The majority of CX training participants indicated that the CX training was helpful. More than one-third of the respondents found the CX training to be extremely or very helpful (38.6 percent), approximately half (47.4 percent) of the participants indicated the training was somewhat helpful. Only 14 percent indicated the training was not helpful to them.

To better understand the features of the training that were helpful or that needed to be improved, the open-ended responses to this question were analyzed. There were 25 respondents who provided additional comments reflecting their experience of the CX training. While 20 percent of the respondents stated that the training aided their implementation of CX, a number of respondents made specific comments that have implications for conducting CX trainings in the future. Forty-four percent indicated that the one-day training was too short to cover the material adequately. Additionally, 12 percent expressed a feeling of “information overload” as a result of attending the training and 12 percent expressed that the training did not provide a complete vision of the entire process. While 4 percent of the respondents indicated that the examples provided in the training were helpful, 16 percent expressed a need for more examples, 12 percent commented that the training was didactic heavy, and 8 percent expressed a need for more practice activities. A few of the respondents (4 percent) indicated it would have been helpful to provide the training materials in advance.

Table 1

Was the CX training helpful to implementing the CX needs assessment? (n=57)

Level of Helpfulness	Frequency	Percentage
Extremely helpful	4	7.0
Very helpful	18	31.6
Somewhat helpful	27	47.4
Not helpful	8	14.0

### CX Planning Guide

The *CX Planning Guide* was a resource for local health departments and their tobacco control coalitions to use as they conducted the CX needs assessment process, prioritized needs assessment findings, and developed objectives. It provided information on the development of CX, lists of the indicators and assets, suggested data sources, indicator and asset worksheets and instructions, a rating guide (rubric) to improve uniformity in the rating of the indicators and assets, information on community planning, information on priority setting, data and community resources, sample objectives, information on evaluation, common questions and answers, a glossary of terms, and sample materials from the pilot projects.

Local program staff users felt the *CX Planning Guide* provided sufficient information to aid implementation of the CX needs assessment process and to develop a comprehensive tobacco control plan. Over 70 percent reported that the information provided by the *CX Planning Guide* was sufficient or highly sufficient.

To better understand the characteristics of the *CX Planning Guide* that were helpful or problematic, the open-ended responses to this question were analyzed. Of the 24 respondents who made comments regarding the *CX Planning Guide*, 20.8 percent indicated they found the *CX Planning Guide* to be too complex. However, very few respondents identified specific recommendations for improving the *Guide*; 4.2 percent indicated that it would have been helpful to have more sample objectives for the Assets, and 4.2 percent indicated they would like to see more priority setting tools in the *Guide*. While 16.7 percent of respondents stated they were confused by the indicator rating section, 8.9 percent indicated that the rating guide for the indicators and assets and the assessment sections were helpful. Overall, 41.7 percent of the respondents made comments suggesting that the *CX Planning Guide* was useful, well organized, and thorough. Additionally, 12.5 percent specifically stated that the *Guide* helped them write objectives.

Table 2

Was the *CX Planning Guide* Sufficient? (n=57)

Level of Sufficiency	Frequency	Percentage
Highly sufficient	10	17.5
Sufficient	30	52.6
Moderately sufficient	16	28.1
Insufficient	1	1.8

### Local Program Evaluation Guide

More than one-third (36.9 percent) of the survey respondents indicated they felt the *Local Program Evaluation Guide* was very or highly valuable and more than half (52.6 percent) indicated it was somewhat valuable. Approximately ten percent expressed that they did not find the *Local Program Evaluation Guide* to be a valuable tool.

To better understand the characteristics of the *Local Program Evaluation Guide* that were helpful or problematic, the open-ended responses to this question were analyzed. Nineteen survey respondents provided comments. In terms of features that were problematic, 21 percent stated they felt the information was either not appropriate to their situation or did not provide sufficient flexibility; 21 percent indicated that they found the *Local Program Evaluation Guide* to be too complex or difficult to understand; 15.8 percent commented that they felt overburdened with information; and 5.3 percent expressed a desire for more sample evaluation designs. Additionally, 15.8 percent commented that the *Local Program Evaluation Guide* was not disseminated timely enough in the process (it was disseminated in May 2001).

In terms of those features that were beneficial, 36.8 percent expressed that overall the *Local Program Evaluation Guide* was helpful and easy to use with 15.8 percent specifically commenting that the sample evaluation designs were helpful.

Table 3

Was the *Local Program Evaluation Guide* Valuable? (n=57)

Level of Value	Frequency	Percentage
Highly valuable	3	5.3
Very valuable	18	31.6
Somewhat valuable	30	52.6
Not valuable	6	10.5



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## CX Assessment Process

The next series of questions assessed the usefulness and benefits of conducting the CX needs assessment. These questions asked about use of the core indicators, noncore indicators, assets, and identification of unanticipated results. In addition to assessing a total of 16 community indicators, each local health department was required to assess each of the 14 community assets.

### Core Indicators

Out of the 62 community indicators, 13 were identified as core indicators. Each of the 61 local health departments was required to assess their local health jurisdiction using the 13 core indicators and to select three noncore indicators of their choice. The core indicators were dispersed across the Priority Areas as indicated in Table 4.

Table 4

Number of Core Indicators by Priority Area

Priority Areas	Number of Community Indicators
Counter Pro-Tobacco Influence	4 (three of these addressed tobacco marketing and deglamorization and one addressed school-based prevention)
Reduce Exposure to Secondhand Smoke	4
Reduce the Availability of Tobacco	3
Promote Tobacco Cessation	2

Approximately one-third (32.4 percent) of the respondents indicated that the core indicators were extremely or very helpful to prioritization, 57.9 percent expressed that they were somewhat helpful, and only 8.8 percent expressed that use of the core indicators was not helpful to prioritizing. The open-ended comments in response to this question did not provide insight as to how the use of core indicators helped prioritize issues. Of the 18 respondents who provided comments; 55.6 percent stated the core indicators “were helpful,” 50 percent commented the indicators “lacked flexibility,” and 27.8 percent stated they were “not helpful.”

Table 5

Did the core indicators help you prioritize? (n=57)

Level of Helpfulness	Frequency	Percentage
Extremely helpful	3	5.3
Very helpful	16	28.1
Somewhat helpful	33	57.9
Not helpful	5	8.8

#### Noncore Indicators

Nearly 37 percent of the respondents indicated that the assessment of noncore indicators was extremely beneficial or very beneficial; 52.6 percent expressed that they were somewhat beneficial and 10.5 percent indicated they were not beneficial. Of the 13 respondents who provided additional comments to this question, lack of flexibility with the indicators (15.4 percent) and a lack of data for the indicators (7.7 percent) were cited as problems with the assessment of noncore indicators. An overwhelming majority of respondents (84.6 percent) made positive comments that were nonspecific, and stated that the activity was beneficial.

Table 6

Was assessment of the noncore indicators beneficial? (n=57)

Level of Benefit	Frequency	Percentage
Extremely beneficial	4	7.0
Very beneficial	17	29.8
Somewhat beneficial	30	52.6
Not beneficial	6	10.5

#### Community Assets

The assessment of community assets addressed those characteristics that facilitate tobacco control work locally. These factors include the availability of funds for tobacco control work, the level that youth and adults engaged in community activism, and the cultural competency of the local health department and its coalition members. Nearly one-half (47.3 percent) of those surveyed indicated that conducting an assessment of the community assets helped to identify deficits in the community with regards to tobacco control funding, the level of advocacy, level of diversity, etc., in their community. Approximately 40 percent indicated that it was somewhat helpful, and only 12.3 percent indicated that the process was not helpful.

Of the 15 respondents who provided additional written comments in response to this question, 73.3 percent made statements to the effect that the process was “helpful;” however, the positive respondents did not illuminate specifically how the process was

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helpful. Those who did not find the process helpful were more specific in expressing their experience with this component of the CX needs assessment: 26.7 percent indicated that the process lacked flexibility or was not generally helpful; 20 percent found it confusing; and 6.7 percent said it was time consuming. Additionally, 6.7 percent commented that the assessment of the assets verified what they already knew.

Table 7

Did assessing the Assets aid you in recognizing deficits in the community? (n=57)

Level of Helpfulness	Frequency	Percentage
Extremely helpful	6	10.5
Very helpful	21	36.8
Somewhat helpful	23	40.4
Not helpful	7	12.3

### Unanticipated Results

Two-thirds of the respondents (66.7 percent) indicated that a few or several unanticipated results were identified as a result of the CX assessment process. This suggests that for a majority of the local health departments, CX was a valuable tool to identify previously unidentified needs. Fourteen respondents made comments regarding this issue. The comments were too varied to group and code. Following are selected comments that describe unanticipated results:

“The asset assessment showed coalition members that we are stronger than they might have thought.”

“One item in looking at indicator assessments was the fact that our use of media was very poor. To help with this issue, one of our health educator’s job description was changed so that she is listed in our work plan as media coordinator.”

“It helped us with our obtaining MSA funds. Just knowing how much was being spent in the county and how low it was—was great.”

“No smoking in doorways was really dropped from the priorities list.”

Table 8

Did the CX needs assessment yield unanticipated results? (n=57)

<b>Magnitude of Unanticipated Results</b>	<b>Frequency</b>	<b>Percentage</b>
Several	9	15.8
A few	29	50.9
None	19	33.3

## **Coalition Member and Nontraditional Partners**

One of CDHS/TCS' goals with CX was to broaden the membership and participation of the community in local tobacco control planning. CDHS/TCS encouraged the involvement of non-local health department staff (tobacco control coalition members and nontraditional partners) in the CX assessment based upon a belief and commitment that tobacco control work is at its best when pursued as a team effort. CDHS/TCS believes that as a result of involving the community in the process a wide variety of skills, ideas, and resources will be brought to bear upon the problem, as well as create greater ownership of the problem and solutions.

### Extent of Coalition Member Involvement

It is evident that local health departments did a very good job of involving their coalition members in meaningful CX activities. Nearly half (47.4 percent) of the respondents indicated that coalition members were highly involved, and 26.3 percent indicated that coalition members were moderately involved in the CX assessment process through the review of data sources and rating indicators. Approximately one-quarter (24.6 percent) reported that their coalition members were minimally involved, and only 1.8 percent indicated that their coalition members were not involved at all.

To better understand how coalition members were involved, the open-ended responses to this question were analyzed and are reported. Of the 17 survey respondents who provided additional comments, 64.7 percent stated that their coalition members conducted the needs assessment rating and completed the CX indicator and asset forms; 35.3 percent stated coalition members participated in priority setting activities; 23.5 percent stated they participated in meetings; and, 5.9 percent stated coalition members conducted community forums.

Table 9

Extent to which coalition members were involved in reviewing data sources and rating indicators? (n=57)

Extent of Coalition Involvement	Frequency	Percentage
Highly involved	27	47.4
Moderately involved	15	26.3
Minimally involved	14	24.6
Not involved	1	1.8

#### Coalition Member Satisfaction

The local health departments were asked to rate their perception of their coalition members' satisfaction with their involvement in CX. The results were very reassuring with more than 70 percent of the respondents indicating that their coalition members were satisfied or very satisfied with their involvement in CX. Additionally, 26.3 percent indicated coalition members were somewhat satisfied, and only 3.5 percent indicated that their coalition members were not at all satisfied.

To better understand how coalition members were involved, the open-ended responses to this question were analyzed and are reported. Fifteen survey respondents provided additional comments. Of those describing positive experiences, 46.7 percent indicated that their coalition members liked being part of the process, 26.7 percent stated their members were satisfied with their involvement, and 20 percent reported that coalition members found their involvement to be helpful. Of those describing negative experiences, 20 percent cited a lack of flexibility or conflict between state and local priorities, 13.3 percent expressed frustration due to the lack of available funding to address all the needs identified in the assessment, and 6.7 percent expressed that CX was too complicated.

Table 10

How satisfied were coalition members with their involvement in CX? (n=57)

Satisfaction Level	Frequency	Percentage
Very satisfied	13	22.8
Satisfied	27	47.4
Somewhat satisfied	15	26.3
Not satisfied	2	3.5

#### Level of Difficulty to Involve Coalition Members

Again, it was reassuring that more than one-half (56.1 percent) of the local health department staff reported that it was not difficult or minimally difficult to involve their coalition

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members in CX. More than one-third (36.8 percent) reported that it was somewhat difficult and seven percent expressed that it was very difficult to involve their coalition members.

To better understand the barriers involved with involving coalition members in conducting the CX assessment process, the open-ended responses to this question were analyzed and are reported. Eighteen survey respondents provided additional comments which provide some helpful insights. By and large, the two largest barriers cited were that time constraints limited coalition member participation (38.9 percent) and that the process required a high level of participation from coalition members (16.7 percent). Additional issues expressed were, in general “it was difficult” (11.1 percent) and less commonly “the process was difficult to explain” (5.6 percent). In terms of positive comments, one-third (33.3 percent) stated that they had active participation, but did not make specific comments as to what that could be attributed to, and 5.6 percent expressed that as coalition members understood CX, this decreased the barriers to obtaining their involvement.

Table 11

Was it difficult to involve coalition members in the assessment process? (n=57)

Level of Difficulty	Frequency	Percent
Not difficult	19	33.3
Minimally difficult	13	22.8
Somewhat difficult	21	36.8
Very difficult	4	7.0

#### Level of Difficulty to Involve Nontraditional Partners

CDHS/TCS defined nontraditional partners as individuals with personal interests or persons representing community organizations other than health, education, and social service agencies. It is evident that local health departments struggled to involve nontraditional partners. The majority of respondents (75.4 percent) indicated it was somewhat or very difficult to involve nontraditional partners. Only one-quarter of the respondents indicated that involvement of nontraditional partners was not difficult or minimally difficult.

To better understand the barriers to involving nontraditional partners in conducting the CX assessment, the open-ended responses to this question were analyzed and are reported. The comments provided by the 22 respondents to this question were mixed, but provide some insights. While 27.3 percent merely commented that they were not successful in their efforts to involve nontraditional partners, two specific reasons were noted by several of the respondents. The most frequently cited barrier was that time constraints limited the ability to involve nontraditional partners (18.2 percent), and a few people (13.6 percent) indicated that the lack of a readily identifiable direct benefit, such as funding, limited the ability to engage nontraditional partners. In contrast, 22.7 percent stated that they had good involvement; 13.6 percent stated that they had some involvement from nontraditional partners; and 9.1 percent indicated that CX was a useful outreach tool to bring in nontraditional partners.

Table 12

Was it difficult to involve nontraditional partners? (n=57)

Level of Difficulty	Frequency	Percentage
Not difficult	7	12.3
Minimally difficult	7	12.3
Somewhat difficult	21	36.8
Very difficult	22	38.6

## Use of Data in the CX Assessment

A key component of California's CX model is to collect data systematically and to use local data strategically. The model focuses on using local data as much as possible to drive decision-making, while recognizing that there may not always be local data for every indicator. CHDS/TCS acknowledged that some times planning groups would need to rely on regional or state level data and qualitative data to guide their decision-making. CDHS/TCS stressed that data should, to the extent possible, be used to justify decisions, but that it was equally important not to become immobilized by too much data or a lack of specific data.

CDHS/TCS encouraged local health departments to gather existing data for use in their assessments rather than collecting new data. To facilitate identification and use of existing data to complete the CX indicator and asset assessment forms, CDHS/TCS: 1) identified a list of possible data sources for each indicator and asset, and 2) prepared a tailored data packet for each local health jurisdiction.

The tailored data packet included the following information:

- Demographic data (by county)
- Adult and youth prevalence data (by county or region and the state)
- Youth access to tobacco data on compliance checks, violations, and calls to the statewide hotline to report illegal tobacco sales (by county)
- Data on exposure to secondhand smoke from clinical office visits from the Child Health Disability Prevention program (by county)
- A listing of major tobacco control policies (by city and county)
- Data on the number of calls to the California Smokers' Helpline (by county)
- A listing of potential tobacco industry sponsored events for 2000 throughout California
- Social will index data (by county)
- Fiscal allocation data for Prop 99 (schools and health departments), Prop 10, and MSA (by county)
- County and statewide data on in-store tobacco advertising
- Various fact sheets and data summaries

To understand whether the collection of the data was difficult for agencies and the value in reviewing data sources, two questions were asked. These probed about the difficulty in finding data sources and whether compiling the data sources was informative.

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Approximately two-thirds (63.2 percent) of respondents indicated that searching for data sources was difficult or somewhat difficult, and 36.9 percent indicated that the search for data was minimally difficult or not difficult.

While the majority of local health departments encountered difficulties with finding data related to the indicators and assets, it appears that use of that data was beneficial and was informative to the CX assessment. Less than one-fifth (17.5 percent) of respondents indicated that use of the data was not informative, 43.9 percent reported that it was somewhat informative, and 38.6 percent reported that it was very informative or extremely informative.

To better understand the issues related to data collection, the open-ended responses to these two questions were analyzed and are reported. Of the 19 respondents who commented about the difficulty of the data search, the two most frequently cited issues were the lack of local data (42.1 percent) and that it was time consuming (26.3 percent). Another 10.5 percent merely stated that it was difficult. There were also several positive comments with 31.6 percent stating that the search for data was not difficult, and 5.3 percent stated that they enjoyed the search for data.

In terms of how informative or valuable the data was, there were 16 respondents who provided comments. Of these, 25 percent indicated that the lack of local data was problematic, 25 percent indicated that no new information was gained (over what they already knew), and 12.5 percent stated that they were overwhelmed by the amount of information and data. A number of respondents commented the data was informative, with 31.3 percent stating it aided their learning about issues, 12.5 percent stating it was valuable to the rating of indicators and assets, and 6.3 percent indicating that it was valuable for writing objectives.

Table 13

Was the search for data sources difficult? (n=57)

Level of Difficulty	Frequency	Percentage
Not difficult	3	5.3
Minimally difficult	18	31.6
Somewhat difficult	23	40.4
Very difficult	13	22.8



Table 14

Was compilation of data sources informative? (n=57)

Level of Informativeness	Frequency	Percentage
Extremely informative	2	3.5
Very informative	20	35.1
Somewhat informative	25	43.9
Not informative	10	17.5

## Overall Impression of CX

Local health departments were asked three open-ended questions to gain a better understanding of the most beneficial and problematic aspects of CX and to give them an opportunity to express any additional thoughts or reactions to the CX approach. They were also asked to indicate whether they would recommend the use of CX by tobacco control programs in other states. The most frequent responses to these questions are discussed below.

## Most Problematic Feature of CX

Comments to this question were provided by 53 respondents. Respondents identified several features that were problematic. The more common themes are grouped together and discussed below.

### Time Constraints

The most common theme among the responses was time constraints (43.4 percent). Respondents expressed that it was difficult to conduct a community assessment and to develop a new comprehensive tobacco control plan while continuing to move their current tobacco control plan forward. They indicated that it was challenging to meet with coalition members, recruit nontraditional partners, gather and analyze the needs assessment data, and complete the CX indicator and asset forms in the time provided. Local health departments were given approximately seven months (from October 2000 to June 2001) to conduct the CX assessment and prioritize and develop their 2001-04 Comprehensive Tobacco Control Plan. A typical comment was as follows:

“Getting the community involvement. Too time consuming. Too much to ask people to do given their time constraints.”

### Lack of Data

The second most common theme expressed (20.8 percent) was that there was a lack of documented local data sources or that data sources were not easily accessible. Some individuals expressed that historical records within their own offices were poorly organized,

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that it was difficult to obtain data from local schools, and that some indicators represented such new areas of tobacco control, that data did not exist for them. A typical comment was as follows:

“We didn’t have data sources for several of the measures, i.e., public support.”

### Inflexible/Too Complex

About 19 percent of respondents expressed that CX lacked flexibility, and 19 percent expressed that it was too complicated. In terms of the lack of flexibility, respondents expressed several thoughts including: a negative feeling about being required to assess the same 13 indicators even if they felt some of them did not apply to their county, a lack of being able to tailor the assessment review tool and questions, and simply that it was too “restrictive.” In terms of CX being confusing, respondents expressed that it was difficult to explain CX to their coalition members. It was a new concept and a great deal of information was provided by CDHS/TCS which had to be summarized because coalition members had less time to understand CX. Many coalition members had never been involved in reviewing data and arriving at conclusions. They also found the rating process confusing. Comments that illustrate these issues are as follows:

“Trying to fit into predefined boxes.”

“Getting traditional tobacco control partners to agree on the sum of the CX rating was difficult. Many of the partners were not clear on the assessment process and its ultimate purpose despite repeated efforts to clarify them.”

### Difficult to Involve the Coalition or Community

Another problem noted by 11.2 percent of the respondents was the difficulty in obtaining coalition member or community involvement. Respondents expressed that coalition members were more used to participating in an advisory capacity rather than getting involved with the review of data, identifying needs, and setting priorities. For some it was difficult to convince coalition members, and others involved, that their assistance in this process was needed; for others gathering the support and interest of nontraditional tobacco control partners proved to be difficult. A comment that illustrates this is the following:

“Trying to meet the expectation re: coalition involvement when our coalition members tend to view themselves as advisory rather than hands on.”

### Other Problems

Issues with priority setting were identified as problematic for 9.4 percent of the respondents—after the community assessments were done it was difficult to agree on the highest priorities and the group came up with issues they thought were important, but they were not supported by the needs assessment findings. Internal problems with staffing, such

as lack of staff experience with conducting a needs assessment and developing a plan, lack of institutional knowledge among staff members, and staff turnover during the process were also cited as problematic for 9.4 percent of the respondents.

Table 15

What was the most problematic feature of CX? (n=53)

Most Problematic Feature	Frequency	Percentage of Respondents
Time constraints	23	43.4
Lacked local data	11	20.8
Lacked flexibility	10	18.9
Too complicated	10	18.9
Lacked community/coalition involvement	6	11.3
Priority setting	5	9.4
Internal problems/staffing	5	9.4
Conflicting state and local priorities	4	7.6
Difficult to involve new partners	3	5.7
Difficult to build consensus	2	3.8
Needed more TA from state	1	1.9
Needed to be more in-depth	1	1.9
Evaluation	1	1.9

## Most Beneficial Aspect of CX

There were 50 respondents who identified beneficial aspects of CX. The most commonly stated beneficial aspects affirmed that two of the CX goals were met. These goals were to:

- 1) Broaden the membership and participation of the community in local tobacco control planning; and
- 2) Implement a systematic framework for assessing community needs and assets.

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## Big Picture

More than one-third of respondents (36 percent) indicated that the most beneficial aspect of CX was that it provided them with the “big picture” regarding their community’s needs. Respondents indicated that CX helped their coalition reflect on what had been accomplished, as well as on-going barriers to progress; that it helped them understand the needs of the community in order to identify where to invest their time and money; and that it forced the coalition to stop and look at other tobacco control issues that they would not have explored otherwise.

Typical comments regarding seeing the big picture were the following:

“It’s difficult to say which was the most beneficial but the assessment process helped us to identify gaps in data and services throughout the county. I feel the CX process provided our coalition members with the opportunity to look at the bigger picture of tobacco control as opposed to seeing only the piece that they provided.”

“Getting a sense of where we were in the big picture of Tobacco Control.”

## Needs Assessment Process

More than 20 percent of respondents indicated that reviewing data, assessing the indicators, and assessing past progress was the most beneficial aspect of CX. The assessment and review of data helped shed light on community needs as well as create awareness about data gaps and data collection needs.

The third most beneficial aspect of CX was identified by 18 percent of respondents for three different themes. These were: 1) increasing coalition involvement; 2) increasing community involvement beyond coalition members; and 3) that CX was valuable as a planning framework. Respondents indicated that involving coalition members energized their coalition members, and that CX provided a structured method to involve coalition members in the planning process. Through their involvement in CX, coalition members became educated about tobacco control, community needs, and developed a sense of responsibility and buy-in for the plan that was completed. CX also provided a means to reach out to new partners, increased awareness of the tobacco control program in the community, and helped identify new partners for local health departments to collaborate with in the future. Several respondents commented that CX was a valuable planning framework because it provided a structured tool to assess the community, that it provided ideas for exploring new areas, and was a rational means to link needs to community assets. One respondent summed it up this way:

“As mentioned previously, the CX process provided an invaluable framework for planning. Although time consuming, having a mandated process did force us to do a much better job of planning and I think we have a very strong plan.”

Table 16

What was the most beneficial aspect of the CX process? (n=50)

Most Beneficial Aspect	Frequency	Percentage of Respondents
Seeing the big picture	18	36
Increasing coalition involvement	9	18
Community involvement	9	18
Valuable planning framework	9	18
Reviewing data	6	12
Identifying new needs	4	8
Increasing networking and local health department collaboration	4	8
Community investment	3	6
Assessing indicators	3	6
Assessing progress	2	4

### Recommendation for Use of CX by Other States

Since the ACS-NHO was involved in disseminating its version of CX in more than 40 states throughout the country at the same time California was implementing CX, CDHS/TCS was eager to find out whether local health departments in California would recommend CX to their counterparts in other states.

Of the 51 respondents to this question, 88.3 percent indicated that they would recommend the use of CX by other states as it was, or with some modifications. Those who provided an unqualified “yes” in response to the question made comments to the effect that they thought CX could be used in other health disciplines, or that it was imperative to get out of a rut and think in other directions, and that CX facilitated that change in thinking.

“I must admit that when this whole CX process started, I was not a happy camper. It seemed very intimidating, even after the trainings. However, when we finally got started doing it, it made a lot of sense. Thanks for helping us in tobacco control grow and look ahead instead of staying where we are and just maintaining.”

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Those who expressed a need for modifications commented that there should have been more time provided for conducting the assessment, that it needed to be less complicated, that California's requirements for everyone to assess the same 13 indicators was too rigid, and that too many indicators were required to be assessed. Only 11.8 percent did not recommend the use of CX by other states. Those who would not recommend it to other states indicated that each county and state knows what is best for them, that CX was not necessary, or that the process was too intense for the return provided. Comments that reflect recommendations for use of CX in other states follow:

"I think the concept and process are very good. I would like to see it simplified so it is easier to explain and less time consuming."

"I think it could be scaled down or the number of indicators that have to be assessed reduced."

"I don't think so. I believe that each county and each state knows what works or does not work in their state. It would be informative to give them the guidelines and then let them work on their own plan."

Table 17

Would you recommend the CX assessment process for use in other states? (n=51)

Recommendation	Frequency	Percentage
Yes	21	41.2
Yes with modifications	24	47.1
No	6	11.8

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## Chapter 5

### State Program Staff User Results

#### Introduction

CDHS/TCS program consultants were surveyed in order to gain insight into the perspective of state staff regarding: 1) the relationship of the quality of the CX assessment to various features of individual plans; and 2) the degree to which CDHS/TCS resources appeared to have been used in the development of these plans. Eleven program consultants completed an assessment related to each local health department plan they reviewed and negotiated. Each consultant was responsible for one to eight plans. Findings are presented for 60 of the 61 local health departments (one health department failed to complete the submission requirements). During the period plans were reviewed, there was turnover among CDHS/TCS program consultants. Consequently, newer staff were not able to respond to some items. Percentages in tables were rounded and may not total 100 percent due to rounding error.

#### CX Benefits

##### Overall Benefit

CDHS/TCS was interested in knowing whether state staff perceived that the local health department benefited from participating in CX. Staff agreed or strongly agreed that 43 of the 57 (75.5 percent) local health departments rated benefited by their participation in CX. Staff disagreed or strongly disagreed that five (8.8 percent) of the health departments benefited from their participation in CX, and they were neutral about its benefit to nine (15.8 percent) of the local health departments.

Table 18

Did the local health department benefit from the CX process? (n=57)

Health Department Benefited	Frequency	Percent
Strongly agree	9	15.8
Agree	34	59.7
Neutral	9	15.8
Disagree	3	5.3
Strongly disagree	2	3.5

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## Coalition Involvement

From a CDHS/TCS staff perspective it was agreed or strongly agreed that 17 (30.4 percent) local health departments broadened their coalition as a result of CX. Staff disagreed or strongly disagreed that 15 (26.7 percent) local health department coalitions were broadened as a result of CX. Staff were neutral on the subject for 24 (42.9 percent) of the local health departments.

Table 19

Did the local health department broaden its coalition as a result of CX? (n=56)

Health Departments Broadened their Coalitions	Frequency	Percent
Strongly agree	1	1.8
Agree	16	28.6
Neutral	24	42.9
Disagree	11	19.6
Strongly disagree	4	7.1

## **Utilization of Resource Materials**

CDHS/TCS put considerable staff resources into the development of the *CX Planning Guide* and the *Local Program Evaluation Guide*. The goal of these resources was that they would improve the implementation of the CX assessment, the development of the plan, and evaluation designs. CDHS/TCS was interested in finding out whether program consultants found evidence that these resources were used by local health departments.

### CX Planning Guide

Staff agreed or strongly agreed that it was evident that 17 (30.4 percent) local health departments used the *CX Planning Guide*. They disagreed or strongly disagreed that 15 (26.7 percent) local health departments used the *CX Planning Guide*.

Table 20

Is it evident that the *CX Planning Guide* was used? (n=60)

Evident that the CX Planning Guide was Used	Frequency	Percent
Strongly agree	15	25.0
Agree	33	55.0
Neutral	10	16.7
Disagree	0	0.0
Strongly disagree	2	3.3



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## Local Program Evaluation Guide

Even though 15.8 percent of local health department staff who made comments about the *Local Program Evaluation Guide* indicated that it was not disseminated in a timely manner, it is evident that CDHS/TCS staff perceived that the document was well used. Staff agreed or strongly agreed that 42 (70 percent) local health departments used the *Local Program Evaluation Guide*. CDHS/TCS staff disagreed or strongly disagreed there was evidence that six (10 percent) local health departments used the *Local Program Evaluation Guide*. They were neutral about the evidence as it related to the evaluation plans submitted by 12 (20 percent) local health departments.

Table 21

Is it evident that the *Local Program Evaluation Guide* was used? (n=60)

<b>Evident that the Local Program Evaluation Guide was Used</b>	<b>Frequency</b>	<b>Percent</b>
Strongly agree	10	16.7
Agree	32	53.3
Neutral	12	20.0
Disagree	4	6.7
Strongly disagree	2	3.3

## **Quality of the Plan**

Two primary goals of CX were: 1) to develop meaningful local tobacco control plans that emphasized community norm change strategies and that were based on the assessment of findings; and 2) to strengthen the state's evaluation of local program efforts by examining similar interventions and analyzing the factors that contribute to successes.

### Consistency of Objectives with the CX Findings

To examine these goals, CDHS/TCS asked staff to rate the extent to which they perceived the objectives to be consistent with the CX assessment findings and probed on a number of questions related to the quality of the plan. Staff reported that for 46 (76.6 percent) of the plans, all or most of the objectives in the plan were consistent with the CX assessment findings. For ten (16.7 percent) of the plans, staff indicated that at least half of the objectives were consistent with the CX assessment findings.

Table 22

Were the objectives consistent with the CX assessment findings? (n=60)

<b>Plans with Objectives that were Consistent with CX Findings</b>	<b>Frequency</b>	<b>Percent</b>
All	23	38.3
Most	23	38.3
Half	10	16.7
Some	3	5
None	1	1

### Quality of the Objectives

The ability of CDHS/TCS to examine similar interventions and analyze the factors that contribute to successes hinges on the quality of the plans. Key elements of a strong plan are well written, measurable objectives; a coherent description of activities that are congruent with each objective; and well-designed evaluations that measure the extent to which the objectives were accomplished. A series of questions were asked related to the quality of the plans.

CDHS/TCS staff indicated that for 53 of the 60 plans (88.4 percent), all or most of the objectives were well written. They also indicated that all or most of the objectives in 56 (93.4 percent) of the plans were measurable. Staff indicated that in seven (11.7 percent) of the plans at least half of the objectives were well written. With four (6.7 percent) of the plans, at least half of the objectives were measurable.

Table 23

Were objectives well written? (n=60)

<b>Plans with Well Written Objectives</b>	<b>Frequency</b>	<b>Percent</b>
All	31	51.7
Most	22	36.7
Half	7	11.7

Table 24

Were objectives measurable? (n=60)

Plans with Measurable Objectives	Frequency	Percent
All	37	61.7
Most	19	31.7
Half	4	6.7

#### Quality of the Activity Plan

If an objective is going to succeed, the activities have to be related to or “match” the objective, i.e., there has to be some likelihood that the activities can lead to accomplishment of the objective. For example, presentations on the dangers of smoking to school-age children are not likely to reduce the rate of illegal tobacco sales, whereas enforcement of a sales to minors law would likely reduce illegal tobacco sales to youths.

CDHS/TCS staff indicated that most or all of the activities matched the objectives in 54 (90 percent) of the plans. For six (ten percent) of the plans, staff reported that at least half of the objectives had activities that were consistent with the desired outcome of the objective.

Table 25

Did the activities match the objective? (n=60)

Plans with Activities that Matched Objectives	Frequency	Percent
All	35	58.3
Most	19	31.7
Half	6	10.0

#### Quality of the Evaluation Activities

Local program evaluation is probably one of the most difficult areas to achieve consistency and quality across the state due to the diversity in resources, capacity, interest, and motivation by local projects. Considerable resources were made available to local health departments to assist them with evaluation. This included the *Local Program Evaluation Guide* and the availability of highly experienced evaluators who could assist LPEs.

Staff reported 55 (93.3 percent) of the plans had evaluation plans that were appropriate to all or most of the objectives and activities within the overall plan. Additionally, staff reported that in four (6.8 percent) of the plans at least half of the evaluation plans were appropriate.

Table 26

Was the evaluation plan appropriate for the objectives and activities? (n=59)

Plans with Appropriate Evaluation Plans	Frequency	Percent
All	28	47.5
Most	27	45.8
Half	4	6.8

#### Assistance of LPE

Since 1996, CDHS/TCS has required local health departments to hire or contract for the services of a LPE. The LPE assists local program staff to develop measurable objectives, and design evaluation activities that are appropriate for the objective and the resources of the health department. LPEs may also assist with the development of survey instruments, focus groups, analyzing data, and report writing.<sup>7</sup> In past years, CDHS/TCS observed and received complaints from LPEs that they were not brought into the evaluation design process early enough.<sup>8,9</sup> CDHS/TCS attempted to correct this situation by inviting LPEs to attend the Local Lead Agency Comprehensive Tobacco Control Plan Guideline training in January 2001, and the May 2001 TA meetings. Additionally, LPE was required to submit a letter at the time the abbreviated plan was submitted. The letter described LPE's involvement in the development of the plan and the number of hours provided in consultation on the development of the plan.

CDHS/TCS was interested in assessing whether staff perceived that LPE was involved in finalizing the plan with CDHS/TCS. Staff reported that for 46 (82.1 percent) of the plans, in all or most of the plans there was evidence that LPE helped finalize it. They reported that in eight (14.3 percent) plans, half or some had evidence that LPE was involved in the finalization of the plan. For two (3.6 percent) of the plans, staff reported there was no evidence that LPE was involved in the finalization of the plan.

Table 27

Was it evident that LPE helped finalize the plan? (n=56)

Quantity of Plans with Evidence of LPE Involvement	Frequency	Percent
All	19	33.9
Most	27	48.2
Half	5	8.9
Some	3	5.4
None	2	3.6

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## Chapter 6

### Evaluator Technical Assistant Consultant (TAC) Results

#### Background

Findings are presented here from LPEs and local health department project directors regarding their experience with TACs who provided TA on evaluation issues to LPEs. Since the response rate to the TAC survey by LPEs was low (34.4 percent) and the overall number of TACs was small, the results discussed below may be biased and must be interpreted with caution. It is possible that the low response rate inflated inaccessibility or other communication issues between a few individuals.

Although a few large local health department programs hire in-house LPEs, the majority of local health departments contract for evaluation services from a consultant or consultant group. The provision of TA by TACs was designed as a peer-to-peer service between the TAC and LPE. The system was designed in this manner to address comments previously provided by LPEs who expressed a desire for direct communication from CDHS/TCS regarding evaluation expectations rather than routing communications through the project director.<sup>10</sup>

TACs consisted of seven university-based or experienced evaluators. They were to provide expert evaluation TA to LPEs as they developed the evaluation portion of their tobacco control plan. They were also involved with reviewing and commenting on the plans submitted to CDHS/TCS and working with LPEs to refine the evaluation design. TACs all had prior experience in tobacco control and had previously or were currently working in the capacity of a LPE. Each TAC was assigned to work with eight to nine local health departments. Mid-way through the process of developing and finalizing local tobacco control plans, one TAC dropped out. The local health departments assigned to this individual were divided between three CDHS/TCS research scientist staff.

TACs were introduced to LPEs and project directors in May 2001 at a face-to-face TA meeting. Individual and group consultation opportunities were provided at that meeting and subsequently made available by telephone and e-mail. TACs provided written feedback on the abbreviated plans submitted by local health departments in June 2001, and feedback was also provided on the final plan submitted in September 2001 using OTIS. Conference calls and face-to-face meetings were held as necessary.

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## TA Methods and Topics

LPEs indicated that they predominantly communicated with their TAC via telephone (66.7 percent) versus e-mail, site visits, group face-to-face meetings, or postal mail. Primarily, TACs provided advice on evaluation design (66.7 percent) and process evaluation methods (33.3 percent). Findings from the survey regarding TAC services are presented below. Percentages in tables were rounded and may not total 100 percent due to rounding error.

### Perceived Benefit

Overall, LPEs responding to the survey did not perceive the experience with TACs to be beneficial. More than half (52.4 percent) indicated their experience with their TAC was poor or very poor. Nearly half (47.6 percent) indicated they did not believe the TACs' involvement helped them prepare their evaluation plans, improve their evaluation plans, or that the suggestions provided were appropriate to the funding and resources available to the local health department.

Project directors expressed a somewhat more positive experience. More than one-third (36.3 percent) indicated that their overall experience with their TAC was good or excellent. Additionally, 45.5 percent agreed or strongly agreed that the TACs involvement helped them prepare their evaluation plans and that the suggestions provided by TACs were appropriate to the funding and resources available to the local health department.

Table 28

#### Overall experience with TAC

Experience	LPE n=21		Project Director n=33	
	Frequency	Percentage	Frequency	Percentage
Excellent	0	0	4	12.1
Good	3	14.3	8	24.2
Neutral	7	33.3	14	42.4
Poor	9	42.9	5	15.2
Very Poor	2	9.5	2	6.1

Table 29

TACs' involvement helped us prepare our evaluation plans

Level of Agreement	LPE n=21		Project Director n=33	
	Frequency	Percentage	Frequency	Percentage
Strongly Agree	2	9.5	6	18.2
Agree	4	19.1	9	27.3
Neutral	5	23.8	11	33.3
Disagree	10	47.6	5	15.2
Strongly Disagree	0	0	2	6.1

Table 30

TAC provided suggestions that were appropriate to our funding and resources

Level of Agreement	LPE n=21		Project Director n=33	
	Frequency	Percentage	Frequency	Percentage
Strongly Agree	1	4.8	6	18.2
Agree	5	23.8	9	27.3
Neutral	5	23.8	10	30.3
Disagree	9	42.9	7	21.2
Strongly Disagree	1	4.8	1	3.0

## Ease of Working With and Access to TAC

Perceptions related to communication issues, the accessibility of TACs, and the ease of working with TACs were fairly consistent between LPEs and project directors.

One-third (33.4 percent) of project directors agreed or strongly agreed that TACs were easy to work with while 28.6 percent of LPEs agreed or strongly agreed with this statement. There was concurrence among LPEs and project directors that TACs were not timely in responding to questions; 42.5 percent of project directors and 42.9 percent of LPEs disagreed or strongly disagreed that TACs provided timely responses to questions.

Table 31

TAC was easy to work with

Level of Agreement	LPE n=21		Project Director n=33	
	Frequency	Percentage	Frequency	Percentage
Strongly Agree	1	4.8	5	15.2
Agree	5	23.8	6	18.2
Neutral	8	38.1	12	36.4
Disagree	3	14.3	7	21.2
Strongly Disagree	4	19.1	3	9.1

Table 32

TAC provided timely responses to questions

Level of Agreement	LPE n=21		Project Director n=33	
	Frequency	Percentage	Frequency	Percentage
Strongly Agree	1	4.8	3	9.1
Agree	2	9.5	5	15.2
Neutral	9	42.9	11	33.3
Disagree	8	38.1	12	36.4
Strongly Disagree	1	4.8	2	6.1

## Consistency of Messages, Amount of Communication, and Level of Cooperation

A common challenge to providing TA is ensuring consistency in the messages provided. Since both CHDS/TCS program consultants and TAC reviewed and commented on the plan, CDHS/TCS was interested in whether there was a perception that the advice provided by these two sources was consistent and perceptions about the quality of the cooperation and communication.

Perceptions regarding consistency of messages and the need for more communication and better cooperation between the parties were very similar for LPEs and project directors. More than one-third (38.1 percent) of LPEs and project directors (36.3 percent) agreed or strongly agreed that comments provided by TACs and CDHS/TCS program consultant were consistent. Additionally, the vast majority of LPEs (71.4 percent) and project directors (72.7 percent) disagreed or strongly disagreed that more communication and better cooperation were needed among the TAC, program consultant, and LPE. These results suggest, that improvement is needed in the consistency of the messages provided to local health departments by TACs and program consultants; however, communication and cooperation were not problematic.



Table 33

The comments from TAC and the program consultant were consistent

Level of Agreement	LPE n=21		Project Director n=33	
	Frequency	Percentage	Frequency	Percentage
Strongly Agree	3	14.3	1	3.0
Agree	5	23.8	11	33.3
Neutral	7	33.3	8	24.2
Disagree	5	23.8	11	33.3
Strongly Disagree	1	4.8	2	6.1

Table 34

More communication and better cooperation are needed among TAC, program consultant, and LPE regarding the evaluation plan

Level of Agreement	LPE n=21		Project Director n=33	
	Frequency	Percentage	Frequency	Percentage
Strongly Agree	0	0	0	0
Agree	1	4.8	3	9.1
Neutral	5	23.8	6	18.2
Disagree	8	38.1	13	39.4
Strongly Disagree	7	33.3	11	33.3

## Training and TA Needs

Two questions were asked related to training needs. Nearly half (47.6 percent) of LPEs agreed or strongly agreed that they need more training and tutoring on evaluation related topics. Nearly two-thirds (63.6 percent) of project directors agreed that their LPE needs more training and tutoring on evaluation related topics.

Conversely, the perception that the project director needs to be more knowledgeable about evaluation was not rated very high by either LPEs or project directors. Among LPEs, 42.9 percent disagreed or strongly disagreed that the project director needed to know more about evaluation, while 48.5 percent of project directors disagreed or strongly disagreed that they needed to know more about evaluation.

These findings suggest that it is appropriate to direct evaluation-related training and TA primarily towards LPEs. There is agreement by a large portion of LPEs and project directors that additional training and TA would be beneficial.

Table 35

LPE needs more training and tutoring on evaluation related topics

Level of Agreement	LPE n=21		Project Director n=33	
	Frequency	Percentage	Frequency	Percentage
Strongly Agree	3	14.3	7	21.2
Agree	7	33.3	14	42.4
Neutral	3	14.3	5	15.2
Disagree	8	38.1	7	21.2
Strongly Disagree	0	0	0	0

Table 36

The project director needs to know more about evaluation

Level of Agreement	LPE n=21		Project Director n=33	
	Frequency	Percentage	Frequency	Percentage
Strongly Agree	2	9.5	3	9.1
Agree	4	19.1	3	9.1
Neutral	6	28.6	11	33.3
Disagree	5	23.8	12	36.4
Strongly Disagree	4	19.1	4	12.1

## Recommendations for Expanding TAC Services to Competitive Grantees

CDHS/TCS was interested in receiving the advice of LPEs and local health department project directors regarding the expansion of TAC concept to its competitive grant program. Additionally, CDHS/TCS asked the project directors whether TACs should have greater involvement in the development of the evaluation plans.

LPEs and project directors had varied responses about extending the TAC concept to the competitive grants program; 42.4 percent of project directors agreed or strongly agreed that the concept should be extended to the competitive grantees, while 28.6 percent of LPEs agreed or strongly agreed with this statement. More than half (57.6 percent) of project directors agreed or strongly agreed that TACs should have more involvement in the development of evaluation plans.

Table 37

CDHS/TCS should extend TACs service to competitively funded projects

Level of Agreement	LPE n=21		Project Director n=33	
	Frequency	Percentage	Frequency	Percentage
Strongly Agree	4	19.1	6	18.2
Agree	2	9.5	8	24.2
Neutral	6	28.6	13	39.4
Disagree	6	28.6	5	15.2
Strongly Disagree	3	14.3	1	3.0

Table 38

TACs should have more involvement in the development of our evaluation plan

Level of Agreement	Project Director n=33	
	Frequency	Percentage
Strongly Agree	9	27.3
Agree	10	30.3
Neutral	8	24.2
Disagree	3	9.1
Strongly Disagree	3	9.1

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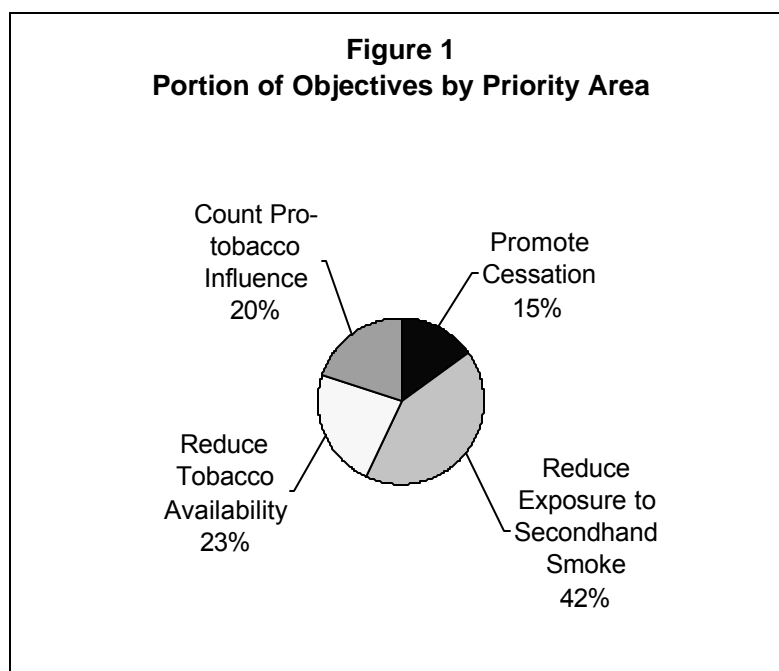
## Chapter 7

### CX Needs Assessment and Plan Results

The combined use of CX and OTIS provides the ability to uniformly capture and report information. Tables 38 and 39 depict the amount of effort and resources directed toward various priority areas and indicators. Through combining the use of CX with an online information system, CDHS/TCS will be able to generate data that allows us to: 1) better understand the link between intermediate indicators and final tobacco-related outcomes; 2) better understand the social, cultural, and political environments that may foster or hinder tobacco control efforts locally; 3) compare communities; and 4) assess the impact of individual or program components. As a result of collecting local program, evaluation, and budget information through OTIS, CDHS/TCS will be able to strengthen the State's ability to evaluate local tobacco control program efforts as a result of standardizing local program evaluation which will permit examination of similar interventions, and analyzing the factors that contribute to successes.

#### Core Indicator and Assessment Results, Related Objectives, and Percent of Effort

There were 376 objectives in the 61 local health department plans. Of these, 90.2 percent (339) were targeted indicators and 9.8 percent (37) were targeted assets. Of the objectives targeting indicators, the breakout by priority area is as follows: 41.9 percent (142) target reduce exposure to secondhand smoke, 23 percent (78) target reduce availability to tobacco, 20.4 percent (69) target countering pro-tobacco influences, and 14.7 percent (50) target promote tobacco cessation services. See Figure 1.



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Of those objectives targeting indicators, 63.1 percent (214) targeted the 13 core indicators. Tables 39 and 40 provide a statewide overview of:

- Statewide CX needs assessment findings for the 13 core indicators and 14 assets;
- Indicators and assets addressed by local health departments;
- The average percent of deliverables (or effort) assigned by local health departments to the activities addressing objectives targeting a specific indicator or asset; and
- The equivalent dollar amount of the 2001-02 LLA budget allocation that the percent of deliverables represents.

Table 39

## Statewide Rating of Core Indicators and the Objectives Addressing Them

Core Indicators	Statewide CX Rating Average (0-4)	Number of Objectives Core Indicators (n=214)	Percent of All Objectives (Core/Noncore Indicators (n=376)	Average Percent Deliverable (Effort) Assigned by LLAs	Equivalent Dollar Amount of 2001-02 Budget Allocation (\$17,426,000)
1. In-store tobacco advertising	1.35	6	1.6	1.53	\$ 266,617.80
2. Exterior tobacco advertising	1.44	11	2.93	4.38	\$ 763,258.80
3. Tobacco sponsorship	1.68	6	1.33	1.98	\$ 345,034.80
18. Tobacco instruction in schools	1.91	10	2.67	2.98	\$ 519,294.80
28. Bar compliance/enforcement	2.41	41	10.93	10.96	\$1,909,889.60
29. Tobacco-free schools compliance	2.60	1	0.27	0.35	\$60,991.00
30. Smoke-free homes	2.19	10	2.67	2.61	\$454,818.60
40. Outdoor smoke-free areas	1.61	33	9.33	10.32	\$1,798,363.20
44. Tobacco sales to minors enforcement	2.23	19	5.07	6.61	\$1,151,858.60
46. Tobacco retail licensing	.44	11	3.47	3.81	\$663,930.60
52. Ban self-service tobacco displays	1.90	18	4.8	6.25	\$1,089,125.00
59. Availability of cessation services	1.88	40	10.67	7.25	\$1,263,385.00
60. Provision of cessation for school students and staff	1.50	8	2.13	1.41	\$245,706.60
Total Funding Directed Toward Core Indicators					\$10,532,274.60

Table 40

## Statewide Rating of Assets and the Objectives Addressing Them

<b>Assets</b>	<b>Statewide CX Rating Average (0-4)</b>	<b>Number of Objectives in 61 Plans (n=214)</b>	<b>Percent of All Objectives (n=376)</b>	<b>Total Percent of Deliverable (Effort) Assigned by LLAs</b>	<b>Equivalent Dollar Amount of 2001-02 Budget Allocation (\$17,426,000)</b>
1. Per capita appropriation for tobacco control	1.70	4	1.07	0.26	\$45,307.60
2. MSA funds for tobacco control	1.10	1	0.27	0.23	\$40,079.80
3. Prop 10 funds for tobacco control	1.52	1	0.27	0.18	\$31,366.80
4. Advocacy training	2.50	3	0.80	0.84	\$146,378.40
5. Coalition satisfaction	2.55	6	1.6	1.09	\$189,943.40
6. Key opinion leader support for tobacco control	2.05	0	0	0	0
7. Youth activism	2.24	11	2.93	3.62	\$630,821.20
8. Adult activism	2.08	4	1.07	0.70	\$121,982.00
9. Participation by nontraditional partners	1.80	6	1.6	0.74	\$128,952.40
10. Diversity of coalition members	2.13	1	0.27	0.19	\$33,109.40
11. Extent of activities targeting diversity	1.90	0	0	0	0
12. Coalition by-laws promote diversity	1.70	0	0	0	0
13. Diversity addressed through materials	2.47	0	0	0	0
14. Diversity of staff and consultants	2.31	0	0	0	
<b>Total Funding Directed Toward Assets</b>					<b>\$1,365,941.00</b>

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## Chapter 8

### Conclusions and Discussion

#### CX Implementation Resources

CDHS/TCS provided a variety of resources to aid local health departments in conducting the CX assessments and prepare their plans. These included providing training, resource guides, and access to expert evaluation TA. Given the considerable resources provided, it is important to understand if the resources were used, valued, and the extent to which they resulted in more favorable outcomes.

##### CX Training

Overall, the majority of local health departments expressed that the CX training aided implementation of CX. While the training was helpful, it is clear from additional comments provided by users that the training could be improved by providing more time to cover the material and incorporation of more participatory activities and concrete examples into the training.

##### CX Planning Guide

Overall, the majority of local health department staff found the *CX Planning Guide* to be a comprehensive and useful tool; however, it would be helpful to simplify the *Guide* and to add materials or training suggestions that health departments could use with their coalition members. From the perspective of CDHS/TCS staff, the *CX Planning Guide* was underutilized. This suggests that methods need to be explored to motivate local health departments to more fully utilize the information and resources provided.

##### Local Program Evaluation Guide

Overall, local health departments found the *Local Program Evaluation Guide* to be a beneficial document. Good use of the document was reflected in the quality of the evaluation activities proposed by local health departments. While a minority of respondents expressed the sentiment that the document was too rigid or difficult to understand, documents such as this are geared for use by a diverse audience with diverse skills and capabilities. Therefore, it is not surprising that the *Local Program Evaluation Guide* would not be universally appropriate to all communities or targeted at the skill level of all the intended users.



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## Coalition Member Involvement

A major finding of this evaluation is that local health departments were successful at involving their coalitions in meaningful activities that moved their members beyond acting in an advisory capacity, to engaging them in conducting assessments, discussing the meaning of data, assigning ratings to indicators and assets, and prioritizing issues. Nearly 50 percent of local health departments reported that their coalition members were highly involved, and the majority of health departments (56.1 percent) also reported that it was not difficult or minimally difficult to involve their coalition members. Despite time constraints and an expectation for a higher level of participation, 70 percent of local health departments reported that their coalition members were satisfied or very satisfied with their involvement in CX. CDHS/TCS staff also perceived that nearly one-third (30.4 percent) of coalitions were broadened as a result of CX. These findings verify that CX expanded the capacity and resources of local planning through greater involvement of the coalition and, in some cases, expansion of the coalition membership.

## Nontraditional Member Involvement

Nontraditional members were defined as persons not involved in health, education, or social services. It is evident that local health departments struggled to gain the involvement of these groups in CX. More than three-quarters of health departments (75.4 percent) reported that it was very difficult or somewhat difficult to involve nontraditional members. Time constraints and the lack of readily identifiable benefits were most commonly cited as the barriers.

It is likely that there were contextual issues that made it difficult to recruit nontraditional partners, such as the lack of existing relationships, time pressures to coalesce data to complete CX assessments, and maintaining progress on the existing plan. However, it is interesting to note that difficulty with involving nontraditional members was associated with difficulty in involving coalition members. This suggests that root causes to this issue go beyond those of the immediate contextual environment. The provision of additional outreach tools, resources, and training may help to address those root causes that stem from the capacity of agencies to outreach and involve nontraditional partners.

## Use of Data in the CX Assessment

It was surprising to find that nearly two-thirds (63.2 percent) of local health departments reported that the search for data sources was somewhat or very difficult. In comparison to many states, California's Tobacco Control Program is rich in terms of data; a data packet was provided to each local health department, the *CX Planning Guide* identified a number of data sources for each indicator, and the Tobacco Education Clearinghouse of California provides library reference services to local health departments. The greatest barriers to identification of data were the lack of specific local data and that it was time consuming to identify data. Less than one-fifth (17.5 percent) of local health departments stated that the review of data was not informative. If local tobacco control programs are to become "more data driven," it is essential that accessibility to data sources be improved, including data collected by locally funded organizations.

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## CX as a Planning Tool

CX was a helpful planning approach to assess needs and gaps. Approximately two-thirds (66.7 percent) of local health departments reported that the CX needs assessment resulted in identification of a few or several results not anticipated prior to going into the assessment process. While CX was a useful planning tool, local health departments expressed concern with the requirement that every health department had to assess the 13 core indicators and 14 assets, even if an agency felt these measures were not applicable to their community.

There are both negative and positive aspects to the standardization of needs assessment, planning, and evaluation activities. The negative aspects include decreasing autonomy, and local program flexibility. Additionally, one could argue that resources are squandered by examining aspects of tobacco control in one's community that do not have relevance to the unique nuances of that community.

However, the core indicators represent those tobacco control efforts that a diverse group of tobacco control experts rated as having the greatest value in terms of moving tobacco control efforts forward and that data were more readily available. Hence, from a statewide perspective, it makes sense to require each health department to assess their community in relationship to these indicators and then to develop objectives to address those areas where there is the most need. Such a requirement increases the probability that communities will direct their resources to those tobacco control issues that will result in the greatest public health gains. Standardization also provides the ability to: 1) create comparisons across communities; 2) improve accountability among low performing local health departments; 3) achieve a larger world view by looking at the "forest" versus individual "trees;" and 4) compels communities to look at issues that they might have ignored because it was an issue that staff deemed of little interest or it lacked political support (e.g., enforcement or compliance with controversial laws).

## Time Constraints -- The Leading Barrier to Implementing CX

Overwhelmingly, 43.4 percent of the local health departments commented that insufficient time was the number one barrier they faced in participating in the CX process. Other key barriers cited were a lack of local data, a lack of flexibility, and that it was too complex.

Local health departments commented that the lack of time made it very difficult for them to stay on task with the expectations of CX and the development of their new plan, at the same time as continuing to make progress on their current plan. In retrospect, local health departments had approximately seven months for this process. In an ideal world, agencies would have had the opportunity to focus their time and efforts solely on their needs assessment activities and development of their new plan. However, government agencies rarely have the luxury to fund applicant agencies to concentrate exclusively on needs assessment and planning activities. There are frequently legislative requirements and political forces that pressure the system to justify its existence as evidenced by tangible public health gains versus process measures such as increased involvement of communities in tobacco control planning.

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Acknowledging the realities of funding in the public sector does not diminish the fact that a majority of local health department staff said they were overwhelmed with their task and the amount of time they had to accomplish the CX activities while at the same time juggling competing priorities. However, it indicates that some solutions to this issue are beyond the exclusive scope and control of the funding agency.

Creating workable solutions to the issue of time constraints is a responsibility that lies with both the state health department and local health departments. There is no panacea that will immediately resolve this issue to the satisfaction of all parties. The solution to this issue realistically rests in such actions as: 1) becoming better at planning the planning process; 2) increasing our efficiency in assessing communities by improving access to data and using new methods to involve coalition members and nontraditional community members that go beyond requiring a large number of face-to-face meetings (e.g., teleconferencing and use of Internet tools such as online rankings of priorities or web boards to communicate and exchange ideas); and 3) improving our ability to effectively communicate our expectations to coalition and community members about the planning process and the benefits to their participation (via development of simplified power point presentations or fact sheets instead of the entire *CX Planning Guide*).

## **Rural versus Suburban/Urban Differences**

Frequently, generalizations are made that there are marked differences between rural communities and suburban or urban communities, or that things that work in suburban/urban communities are not appropriate or do not work in rural communities. To explore this issue further, CDHS/TCS conducted correlation analyses to examine the differences between local health departments that identified themselves as rural and those that identified themselves as suburban or urban. Thirty-six health departments identified themselves as representing rural areas, 16 identified themselves as representing suburban areas, and 9 identified themselves as representing urban areas. Suburban and urban counties were analyzed together because the sample for urban counties was small.

Based on the CDHS/TCS staff survey, there were very few significant findings based on rural versus suburban/urban differences. CDHS/TCS staff perceived that suburban/urban local health departments were more likely to broaden their coalition as a result of their participation in CX than rural local health departments ( $p=0.04$ ). This may be a product of the fact that there are simply fewer people to engage in rural areas compared to suburban/urban areas. The only other significant finding was that CDHS/TCS staff perceived that 83.3 percent of the suburban/urban local health departments used the *CX Evaluation Guide*, while only 61.1 percent of rural local health department used it ( $p=0.09$ ). This may be due to the ability of suburban and urban areas to hire staff with greater evaluation expertise, or the fact that they may have had more staff and, thus, had more time to effectively use the *CX Evaluation Guide*.

Surprisingly, no significant differences were found between rural local health departments and suburban/urban local health departments related to their experiences with CX resources, coalition and nontraditional member involvement, coalition member satisfaction with their participation, unanticipated findings, using core indicators to prioritize, benefits to the assessment of noncore indicators, overall benefits to participating in CX, or overall

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barriers to participation in CX. These findings provide evidence that CX is a tool that has universal applicability in communities of varying size and resources.

## **Well Developed Tobacco Control Plans—An Outcome**

The tobacco control plans that resulted from the CX process were predominately grounded in the needs assessment findings and included well written, measurable objectives. Program and evaluation activities tightly corresponded to the objectives, which strongly suggests that the objectives have a high likelihood of success and that the evaluation activities will be able to measure the extent to which activities were accomplished and the effectiveness of activities. CDHS/TCS staff reported that in more than three-fourths (76 percent) of the plans, objectives were consistent with the needs assessment findings. In more than 90 percent of the plans, all (61.7 percent) or most (31.7 percent) of the objectives were deemed measurable, and in more than 87 percent of the plans, all (51.7 percent) or most (36.7 percent) of the objectives were well written. In more than 90 percent of the plans, all or most of the program activities matched the objectives, and in more than 93 percent of the plans, all or most of the evaluation activities were appropriate to the objective and activities.

Overall, CDHS/TCS staff perceived that 75 percent of local health departments benefited from participation in CX. From the analyses discussed next in this report, those who benefited were more likely to use the resources provided to them and adhere to the CX framework and goals.

## **Who Benefited from CX and What Factors are Associated with Benefiting?**

Correlation analyses were conducted to better understand: 1) the value of the resources provided to local health departments; 2) who benefited from CX; and 3) how local health departments benefited from the use of the CX resources and their participation in CX. Following is a discussion of these findings. All the correlations discussed are statistically significant ( $p \leq .05$ ).

The CDHS/TCS staff perception that those local health departments who made good use of the resources available (CX plan and evaluation guides and LPE) was associated with greater benefits from CX, greater coalition involvement, and a stronger plan. Use of the CX planning and evaluation guides was also closely linked. The perception that local health departments benefited from the CX process was correlated with the perceived use of the CX *Planning Guide* ( $r=0.71$ ) and use of the *Local Program Evaluation Guide* ( $r=0.52$ ), and that participation in CX broadened the local health department's coalition ( $r=0.56$ ). This suggests that those local health departments that adhered to the CX framework and goals were the ones that benefited the most from their participation in CX.

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As would be expected, evidence that the LPE helped finalize the plan was associated with submission of a plan that contained evaluation activities that were consistent with and appropriate to the objectives and activities contained in the plan ( $r=0.63$ ). Clearly, involvement of the LPE increased the chance that the local health department developed a stronger evaluation component to their plan.

Interestingly, there was no relationship between the opinion of CDHS/TCS staff about the quality of services provided by TACs and evidence that the *Local Program Evaluation Guide* was well used by local health departments. While CDHS/TCS expected that TACs would actively promote the *Local Program Evaluation Guide*, a perception that they did or did not, was not related to the perceived value of the services provided by TACs.

Local health department staff who valued the CX process were likely to identify that CX benefited them in terms of identifying asset deficits and prioritizing programmatic needs. Local health department staff who expressed that the use of the core indicators helped them prioritize their needs was related to the extent to which they thought the *CX Planning Guide* was sufficient ( $r=0.57$ ) and expressed that the *Local Program Evaluation Guide* was valuable ( $r=0.56$ ). This implies that the use of CX resource materials to conduct the assessment and evaluation helped the local health department grasp and “buy into” the vision CDHS/TCS had for requiring that assessments be conducted for the core indicators.

Not surprisingly, the local health departments that found it difficult to involve coalition members also found it difficult to involve nontraditional partners ( $r=0.50$ ). This suggests that in communities where the coalition is weak, bringing new partners to the table is not feasible. Additionally, it could be a marker of poor support in the community and political environment for tobacco control or reflect on the skills and capacity of a local health department to reach out to and obtain involvement of community members.

## **What Were the Beneficial Aspects of Participating in CX?**

CX provided a systematic framework for assessing community needs and assets, and the assessment provided a foundation for the local health departments to create their plans. More than one-third (36 percent) of the health departments indicated that a primary benefit of participating in CX was that they were able to see the big picture in their community related to tobacco control issues, and 18 percent commented that CX provided a valuable planning framework from which to work. CDHS/TCS affirmed the value of CX as a planning framework in their observation that in 76 percent of the plans submitted, all or most of the objectives reflected findings from the needs assessment.

## **TAC Services**

The results regarding the value of the expert TAC services are inconclusive due to the low survey response rate. However, the results suggest that LPEs desire help to improve their abilities to effectively evaluate local tobacco control interventions. At the same time, the concept of using university-based evaluators to provide TA consultation directly to LPEs

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needs to be refined. Improvement in the consistency of advice provided by CDHS/TCS program staff and TACs is needed.

## **Improvement of Tobacco Control Program Evaluation**

In conclusion, CX is a useful planning approach for rural, suburban, and urban communities. Additionally, in combination with California's OTIS, it has the potential to provide information that will improve the State's evaluation of tobacco control program efforts. In June 2001, a national workshop on evaluation of tobacco control interventions was convened by the Institute of Global Tobacco Control at the Johns Hopkins Bloomberg School of Public Health.<sup>1</sup> Participants in this workshop identified a number of evaluation challenges facing comprehensive tobacco control programs and identified recommendations for addressing these challenges. Among the challenges identified were the heterogeneity of exposure information, the lack of information documenting the implementation of process outcomes, and the lack of systematic data collection across states and local communities which impacts the ability to determine the impact of programs in the presence of secular trends.

Among the recommendations presented by the workshop were the need to: 1) link key intermediate indicators to final outcomes; 2) support qualitative studies to capture the readiness of communities in terms of social, cultural, and political environment; 3) develop a state report card or ranking system to compare state tobacco control activities; and 4) develop online reporting systems to assess individual contributions or program components.

States that tie implementation of CX to local program funding and use an online reporting system to capture local tobacco control plans, progress, and fiscal reports have the ability to address many of the recommendations made in this workshop. Organizing local tobacco control objectives and interventions by indicators provides the ability to analyze the effectiveness of similar interventions and may provide the ability to link intermediate indicators to final outcomes such as prevalence and consumption. Through the CX needs assessment process, information on the social, cultural, and political environment are systematically collected, which could provide a rich qualitative data source for investigators interested in examining the readiness of communities to implement policy and enforcement interventions. Combining the use of the CX needs assessment process with an online database system to capture the needs assessment findings, local tobacco control plans, and process implementation increases the ability of state evaluation efforts to compare communities and assess the value of individual efforts or program interventions.

As noted in the workshop proceedings, the benefit of investing time and financial resources into systems that more effectively capture the nature and impact of local programs is that it can lead to more effective tobacco control programs through the identification and promotion of more effective strategies, and by maintaining the financial and political support for comprehensive tobacco control programs.

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## Chapter 9

### Recommendations

1. Revamp the CX training by increasing its length and the amount of time provided for practical activities and discussion.
2. Revamp the *CX Planning Guide* with simplification in mind, as well as adding tools such as Power Point presentations, fact sheets, and outreach tools that can be used to explain the essential elements of CX to coalition members and nontraditional partners. Create a searchable CX Web site, from which tools can be downloaded, tailored and locally developed materials or strategies can be posted.
3. Work with representatives of high priority populations (based on their high use of tobacco and targeting by the tobacco industry) to create a *CX Planning Guide* that is more tailored to their communities.
4. Work with representatives of high priority populations to educate more traditional coalitions on how to better gain the involvement of high priority populations in tobacco control activities.
5. Improve the accessibility of tobacco control related data by local groups involved in tobacco control planning:
  - Develop a Web site with appropriate local, regional, and statewide tobacco control data;
  - Improve access to local program evaluation reports by abstracting these reports and making them available through Inmagic searches available through the Tobacco Education Clearinghouse of California; and
  - Create portable document format files out of higher quality local program evaluation reports and make them available through the Tobacco Education Clearinghouse of California Web site, *The STORE Campaign* Web site, etc.
6. Provide more TA and support to agencies to prepare for the planning process, including exploring new methods for gaining community input and consensus building. This may include more explicit timelines, periodic check-ins with agencies to assess progress and guidelines for the use of teleconferences, Web boards, and other technology to decrease the burden of face-to-face meetings.
7. Explore working with ACS-NHO and TA and Training Center to package intervention tool kits that complement sample objectives and evaluation plans.
8. Improve communication between TACs and LPEs including clarifying roles and expectations.
9. Revamp the *Local Program Evaluation Guide* and provide more training to LPEs to aid their ability to effectively evaluate local program efforts.

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## CX Indicators

### **Priority Area: Counter Pro-Tobacco Influences** ***Tobacco Marketing and Deglamorization Indicators***

**Definition:** Tobacco marketing and deglamorization indicators address the: 1) marketing tactics used to promote tobacco products and their use, 2) public image of tobacco companies, and 3) activities to counter the marketing, glamorization, and normalization of tobacco use.

1. Extent of in-store tobacco advertising and promotions  
-or-  
the proportion of communities with policies that control the extent of in-store tobacco advertising and promotions.
2. Extent of tobacco advertising outside retail stores  
-or-  
the proportion of communities with policies that control the extent of tobacco advertising outside retail stores.
3. Extent of tobacco sponsorship at public (e.g., county fair) and private (e.g., concert, bars) events  
-or-  
the proportion of entertainment and sporting venues with policies that regulate tobacco sponsorship.
4. Extent of tobacco advertising and sponsorship at college related events  
-or-  
the proportion of colleges with policies to control the extent of tobacco advertising and sponsorship at college related events.
5. Extent of tobacco company-sponsored bar and club nights and related advertising.
6. Extent of tobacco advertisements in magazines, newspapers, and other print media  
-or-  
the proportion of magazines, newspapers, and other print media that control the extent of tobacco advertisements.
7. Extent of outdoor tobacco ads and billboards that are less than 14 square feet.
8. Extent of compliance with MSA outdoor advertising, print advertising, sponsorship, and promotional requirements.
9. Extent of tobacco company contributions to educational, research, public health, women's, cultural, entertainment, fraternity/sorority groups, and social service institutions.
10. Extent of tobacco company contributions to support political campaigns of elected officials.

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| 11. Extent of socially responsible depiction of tobacco use, tobacco advertising, and ETS restrictions by the entertainment industry. |
| 12. Extent of the availability of candy look alike tobacco products.  |
| 13. Extent of news media stories about tobacco industry deception.  |
| 14. Extent of public school districts with a policy prohibiting wearing or carrying of tobacco promotional items at school.           |

**Priority Area: Counter Pro-Tobacco Influences**  
*Reduce Tobacco Industry Influence Economic Indicators*

**Definition:** The economics community indicators address the financial incentives and disincentives that can be implemented to promote non-tobacco use norms.

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| 15. Extent of public (e.g., county and city government) and private institutions (e.g., unions, private university) that divest of tobacco stock.  |
| 16. Extent of public and private employers that offer discounted health insurance premiums for non-tobacco users.  |
| 17. Extent of public school districts and public institutions, such as hospitals or correctional facilities, that adopt a selective purchase policy indicating that tobacco company subsidiary food products will not be bought. |

**Priority Area: Counter Pro-Tobacco Influences**  
***School-and Community-Based Prevention Indicators***

**Definition:** The school and community-based prevention community indicators address the availability and provision of tobacco use prevention information to youths in school and youth serving programs such as the Scouts or 4-H.

18. Proportion of schools that provide intensive tobacco use prevention instruction in junior high/middle school years with reinforcement in high school using a curricula that provides instruction on the negative physiologic and social consequences of tobacco use, social influences on tobacco use, peer norms regarding tobacco use, and refusal skills.  
(CDC Guideline)

18.1 Proportion of youth serving programs that provide intensive tobacco use prevention instruction using a curricula that provides instruction on the negative physiologic and social consequences of tobacco use, social influences on tobacco use, peer norms regarding tobacco use, and refusal skills.

19. Extent of teachers who report receiving tobacco use prevention specific training for teachers.  
(CDC Guideline)

20. Extent of school districts that involve parents or families in support of school-based tobacco use prevention.  
(CDC Guideline)

**Priority Area: Countering Pro-Tobacco Influences**  
***Physical Environment Indicators***

**Definition:** The physical environment community indicators address the pollution and safety hazards posed to the natural environment by the production and use of tobacco products.

21. Extent of public policies controlling tobacco litter in public places including parks, playgrounds, and beaches.

22. Extent of low-income housing complexes that have cigarette related fire prevention policies.

**Priority Area: Countering Pro-Tobacco Influences**  
*Global Movement Indicators*

**Definition:** The global movement community indicators address: 1) countering the international sale and promotion of tobacco products by U.S. tobacco companies in other countries; and 2) building the capacity of other countries to respond to the marketing and sales practices of U.S. tobacco companies.

23. Extent of local resolutions in support of national policies to hold U.S. tobacco companies to the same standards in the sale and marketing of their products nationally and internationally.

24. Extent of local resolutions in support of national policies to hold U.S. tobacco companies to the same standards in their production of tobacco products nationally and internationally, e.g., pesticide use, genetic engineering, etc.

25. Extent of local resolutions in support of the WHO Framework Convention on Tobacco Control.

26. Extent that local tobacco control programs exchange information and resources to build tobacco control efforts internationally in response to U.S. tobacco company marketing and sales practices.

**Priority Area: Reduce Exposure to Secondhand Smoke**  
***Reduce Exposure to Secondhand Smoke Indicators***

**Definition:** The secondhand smoke community indicators address secondhand smoke exposure in indoor and outdoor settings.

27. Extent of enforcement/compliance with state/local smoke-free worksite law(s) *(excluding bars and gaming)*.

27.1 Proportion of American Indian tribes with tribal smoke-free worksite policies.

27.2 Extent of enforcement/compliance with American Indian tribal smoke-free worksite law(s) *(excluding bars and gaming)*.

28. Extent of enforcement/compliance of enforcement of state/local smoke-free bar and gaming law(s).

28.1 Extent of enforcement/compliance with American Indian tribal smoke-free bar and gaming law(s).

29. Extent of compliance with the state law that prohibits the use of tobacco by all students, school staff, parents, and visitors in public school, district-owned or leased buildings, on district grounds, and in district vehicles.

30. Proportion of homes with a smoker in the household who report their home is smoke-free.

31. Proportion of families with a smoker who report their personal vehicles are smoke-free.

32. Proportion of worksites with five or fewer employees that have smoke-free policies

-or-

the proportion of communities with policies that make worksites with five or fewer employees be smoke-free.

33. Proportion of hotels with smoke-free lobby policies

-or-

the proportion of communities with policies that require hotel lobbies to be smoke-free.

34. Extent of foster care homes that are designated as smoke-free.

35. Extent of multi-unit housing and public housing complexes with policies that designate common outdoor areas as smoke-free, (e.g., playground, swimming pool).

36. Extent of public and private worksites that designate smoke-free entrances within 15 feet or more of the outside doorways -or- proportion of communities with policies that designate smoke-free entrances within 15 feet or more of the outside doorways.
37. Extent of smoke-free units within multi-housing complexes (e.g., apartments and public housing).
38. Extent of single resident occupancy hotel rooms that designate a portion of rooms as smoke-free.
39. Extent of restaurants and bars with outdoor areas that designate the outdoor area as smoke-free.
40. Extent of outdoor recreational facilities, (e.g., fairgrounds, amusement parks, playgrounds, sport stadiums, etc.) that have policies designating a portion or all the outdoor areas as smoke-free.
41. Extent of private elementary and high school campuses designated as tobacco-free.
42. Extent of movie theaters, sporting events, and entertainment events that designate waiting lines for tickets, food service, restrooms, etc., as smoke-free.
43. Extent of faith community events that are designated as smoke-free.

**Priority Area: Reduce the Availability of Tobacco**  
***Reduce the Availability of Tobacco Indicators***

**Definition:** The reduce the availability of tobacco community indicators address controlling the sale, distribution, sampling, or furnishing of tobacco products within the community.

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| 44. Extent of compliance with state laws prohibiting the sale of tobacco to minors and requiring ID checking.   |
| 45. Extent of compliance with posting the STAKE Act age-of-sale warning signs.  |
| 46. Proportion of communities with tobacco retail licensing.  |
| 47. Extent that bidis, cigars, and smokeless tobacco products are included and tracked as part of compliance checks for enforcement of illegal tobacco sales to minors. |
| 48. Extent of compliance with state and local laws restricting placement of vending machines.   |
| 49. Extent of compliance with state no sales-of-single cigarettes law.  |
| 50. Extent of compliance with the MSA sales and distribution of tobacco requirements.   |
| 51. Proportion of communities that regulate the number, location, and density of tobacco retail outlets, e.g., conditional use permits.                                 |
| 52. Proportion of communities that control self-service sales of tobacco.   |
| 53. Proportion of independent and chain pharmacy stores that do <i>not</i> sell tobacco.  |
| 54. Proportion of communities that have eliminated all tobacco vending machine sales.   |
| 55. Proportion of communities that control tobacco sales via mobile vendors.  |
| 56. Proportion of communities that prohibit free tobacco products sampling.   |
| 57. Proportion of stores in the community that sell bidis or flavored cigarettes.   |
| 58. Proportion of minors reporting they have received tobacco from a social source.   |

**Priority Area: Promote Tobacco Cessation Services**  
***Promote Tobacco Cessation Services Indicators***

**Definition:** The promote tobacco cessation community indicators address the availability and provision of behavior modification focused tobacco cessation services that are culturally and linguistically appropriate for the community.

59. Extent of the availability and use of culturally and linguistically appropriate behavior modification-based tobacco cessation services in the community.

60. Extent of public school districts that provide cessation support for students and all staff who use tobacco.  
(CDC Guidelines)

61. Extent of public employee health care plans that have implemented the Public Health Service clinical practice guidelines.

62. Extent of managed care organizations serving the community that have implemented the Public Health Service clinical practice guidelines.



## CX Assets

### Tobacco Control Funding Assets

**Definition:** Tobacco control funding assets reflect the extent funding is available for tobacco control activities.

1. Per capita appropriation for tobacco control activities, from various sources, is consistent with the recommendations of the National Association of County and City Health Officials:
  - < 100,000 population: \$8-\$10/capita
  - 101,000-500,000 population: \$6-\$8/capita
  - ≥ 501,000 population: \$4-\$6/capita.
2. Extent MSA funds are appropriated for the purpose of tobacco control activities.
3. Extent local Prop 10 funds are appropriated for cessation, and secondhand smoke education targeting pregnant women and families with young children.

### Social Capital Assets

**Definition:** The social capital assets reflect the extent people and organizations work collaboratively in an atmosphere of trust to accomplish goals of mutual benefit.

4. Extent CDHS/TCS-funded projects in the health jurisdiction provide tobacco control advocacy training for youth and adults to develop community leaders.
5. Extent of satisfaction with program planning, involvement of the community, implementation, quality of services, and progress made by coalition members.
6. Extent of support by local key opinion leaders for tobacco related community norm change strategies.
7. Extent of community activism among youth to support tobacco control.
8. Extent of community activism among adults to support tobacco control.
9. Extent of participation of nontraditional partners in tobacco control coalitions.

## Cultural Diversity and Cultural Competency Assets

**Definition:** Cultural diversity and cultural competency assets are behaviors, attitudes, and policies among CDHS/TCS-funded projects that enable effective work in cross-cultural situations within the community. Culture refers to patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious, or social groups. Competence implies having the capacity to function effectively as an individual or organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and the community.

10. Extent of participation by ethnically and culturally diverse groups on community tobacco control coalitions in relation to their proportion in the community.
11. Extent to which the LLA and other CDHS/TCS-funded projects in the health jurisdiction include specific objectives in their workplans/scopes of work to address cultural or ethnic/minority communities or populations in relation to the demographics of the community.
12. Extent that the LLA tobacco control coalition by-laws and coalition member agency mission statements promote cultural diversity and competence.
13. Extent that educational and media materials used by the LLA and CDHS/TCS-funded projects in the health jurisdiction reflect the cultures, ethnic backgrounds, and languages of the communities served in relation to the demographics of the community.
14. Extent that bilingual staff, subcontractors and consultants are part of LLA and CDHS/TCS-funded projects in proportion to the demographics of the local health jurisdiction.